OREGON BULLETIN

Supplements the 2013 *Oregon Administrative Rules Compilation*

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Published by
KATE BROWN
Secretary of State

INFORMATION AND PUBLICATION SCHEDULE

General Information

The Administrative Rules Unit, Archives Division, Secretary of State publishes the *Oregon Administrative Rules Compilation* and the online *Oregon Bulletin*. The *Oregon Administrative Rules Compilation* is an annual print publication containing complete text of Oregon Administrative Rules (OARs) filed through November 15 of the previous year. The *Oregon Bulletin* is a monthly online supplement that contains rule text adopted or amended after publication of the print *Compilation*, as well as proposed rulemaking and rulemaking hearing notices. The *Bulletin* also publishes certain non-OAR items when they are submitted, such as Executive Orders of the Governor, Opinions of the Attorney General, and Department of Environmental Quality cleanup notices.

Background on Oregon Administrative Rules

ORS 183.310(9) defines "rule" as "any agency directive, standard, regulation or statement of general applicability that implements, interprets or prescribes law or policy, or describes the procedure or practice requirements of any agency." Agencies may adopt, amend, repeal or renumber rules, permanently or temporarily (up to 180 days), using the procedures outlined in the *Oregon Attorney General's Administrative Law Manual*. The Administrative Rules Unit assists agencies with the notification, filing and publication requirements of the administrative rulemaking process.

How to Cite

Every administrative rule uses the same numbering sequence of a three-digit chapter number followed by a three-digit division number and a four-digit rule number (000-000-0000). Example: Oregon Administrative Rules, chapter 166, division 500, rule 0020 (short form: OAR 166-500-0020).

Understanding an Administrative Rule's "History"

State agencies operate in a dynamic environment of ever-changing laws, public concerns and legislative mandates which necessitate ongoing rulemaking. To track changes to individual rules and organize the rule filing forms for permanent retention, the Administrative Rules Unit has developed for each rule a "history" which is located at the end of the rule text. An administrative rule "history" outlines the statutory authority, statutes implemented and dates of each authorized modification to the rule text. Changes are listed in chronological order and identify in abbreviated form the agency, filing number, year, filing date and effective date. For example: "OSA 4-1993, f. & cert. ef. 11-10-93" documents a rule change made by the Oregon State Archives (OSA). The history notes this was the 4th filing from the Archives in 1993, it was filed on November 10, 1993 and the rule changes became effective on the same date. The most recent change to each rule is listed at the end of the "history."

Locating the Most Recent Version of an Administrative Rule

The online *OAR Compilation* is updated on the first of each month to include all rule actions filed with the Administrative Rules Unit, Secretary of State's office by the 15th of the previous month. The annual printed *OAR Compilation* contains the full text of all rules filed through November 15 of the previous year. Subsequent creation of or changes to individual administrative rules are listed by rule number in the OAR Revision Cumulative Index, which is published monthly in the online *Oregon Bulletin*. These listings include the effective date, the specific rulemaking action, and the issue of the *Bulletin* that contains the full text of the adopted or amended rule. The *Bulletin* includes text for both Permanent and Temporary rules.

Locating Administrative Rules Unit Publications

The *Oregon Administrative Rules Compilation* and the *Oregon Bulletin* are available on-line at <http://arcweb.sos.state.or.us/pages/rules/index.html>. Printed volumes of the *Compilation* are deposited in Oregon's Public Documents Depository Libraries listed in OAR 543-070-0000. Complete sets and individual volumes of the *Compilation* may be ordered by contacting: Administrative Rules Unit, Archives Division, 800 Summer Street NE, Salem, OR 97310, (503) 373-0701, Julie.A.Yamaka@state.or.us

Filing Adminstrative Rules and Notices

All hearing and rulemaking notices, and permanent and temporary rules, are filed through through the OAR online filing system at <http://arcweb.sos.state.or.us/pages/rules/index.html>. To expedite the rulemaking process, agencies are encouraged to file a Notice of Proposed Rulemaking Hearing specifying hearing date, time and location, and to submit their filings early in the submission period. All notices and rules must be filed by the 15th of the month to be included in the next month's *Oregon Bulletin* and *OAR Compilation* postings. Filings must contain the date stamp from the deadline day or earlier to be published the following month.

Reminder for Agency Rules Coordinators

Each agency that engages in rulemaking must appoint a rules coordinator and file an "Appointment of Agency Rules Coordinator" form with the Administrative Rules Unit, Archives Division, Secretary of State. Agencies which delegate rulemaking authority to an officer or employee within the agency must also file a "Delegation of Rulemaking Authority" form. It is the agency's responsibility to monitor the rulemaking authority of selected employees and to keep the appropriate forms updated. The Administrative Rules Unit does not verify agency signatures as part of the rulemaking process. Forms are available at <http://arcweb.sos.state.or.us/pages/rules/index.html> or from the Administrative Rules Unit, Archives Division, 800 Summer Street NE, Salem, Oregon 97301, (503) 373-0701.

Publication Authority

The *Oregon Bulletin* is published pursuant to ORS 183.360(3). Copies of the original Administrative Orders may be obtained from the Archives Division, 800 Summer Street, Salem, Oregon, 97310; (503) 373-0701. The Archives Division charges for such copies.

Note: The official copy of an Oregon Administrative Rule is contained in the Administrative Order filed at the Archives Division. Any discrepancies with the published version are satisfied in favor of the Administrative Order.

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EXECUTIVE ORDER NO. 13 - 07

DETERMINATION OF A STATE OF EMERGENCY IN JOSEPHINE COUNTY DUE TO EXTREME FIRE

Pursuant to ORS 476.510 through 476.610, I find that an extreme fire has caused and immediately threatens to cause local adverse natural and economic disaster in conditions in Josephine County. The conditions have resulted in loss of structures and vehicle, voluntary evacuations of one town, threats to additional structures, and broad impacts to timber lands.

The high temperatures and erratic winds caused the fire to grow quickly. Approximately 500 acres were burned. Professional and volunteer firefighters are to be commended for their fire defense efforts and success in limiting damages and protecting life and property under challenging conditions.

The conditions resulting from the Pacifica Fire threaten significant economic loss to Josephine County, as well as to the county's agricultural and natural resource land bases.

A timely response to this situation is vital to the well being and economic security of the citizens and businesses in the region. I am therefore declaring a state of emergency in Josephine County and direct the following activities:

IT IS HEREBY ORDERED AND DIRECTED:

1. The Oregon State Fire Marshall shall activate an Incident Management Team to deploy Command and General Staff elements to the fire.

2. The Oregon State Fire Marshall shall activate all necessary Task Forces to assist with containment.

3. All other departments are directed to coordinate with the above agency and to provide appropriate state resources as determined essential to assist affected political subdivisions in Josephine County.

This emergency is declared only for Josephine County and expires on December 31, 2013

This order was made by verbal proclamation at 5:17 p.m. the 19th day of July, 2013.

Done at Salem, Oregon this 25th day of July, 2013.

/s/ John A. Kitzhaber
John A. Kitzhaber, M.D.
GOVERNOR

ATTEST

/s/ Kate Brown
Kate Brown
SECRETARY OF STATE

EXCUTIVE ORDER NO. 13 - 08

CHARTERING PARTNERSHIPS FOR JOB GROWTH AND TALENT DEVELOPMENT

For too many Oregonians, continued economic recovery will not translate into a more prosperous future. Those who worked in low wage jobs even before the recession, those whose middle income jobs have disappeared, and young people who cannot find entry-level jobs are not likely to realize the full potential of a recovering economy. The well-being of our state is in jeopardy if these citizens, many with families to support, are unable to benefit from economic opportunity.

At the same time, there are businesses struggling to find workers with the right skills to support future growth and increase productivity. In the past, a recovering state economy resulted in job growth and reduced unemployment; however, job growth has not kept pace in the current recovery. Changing dynamics in our economy related to jobs, job creation and relationships between employers and employees mean that our traditional approaches to preparing people for and matching them to employment will also have to change.

Despite strong efforts to integrate program services, the outdated state and federal patchwork of programs spread across several agencies that make up the workforce system challenges the efficiency with which we can create solutions for the changing economy. In addition, federal and state funds for workforce programs have been in decline for almost a decade and are not likely to increase, even as our economic challenges continue well past the end of the Great Recession. Reductions in federal program funding, paired with the demands of the new economy, create the urgent need for Oregon to better align its workforce system with changing priorities, integrate more workforce programs, clarify roles and responsibilities and redesign systems. The longer we wait the fewer choices we have.

New workforce solutions cannot be developed by government alone. Businesses, business associations, and economic development organizations across Oregon must be engaged pro-actively to develop solutions that increase employment in small and mid-sized businesses, as well as large companies.

The path forward requires bold partnerships among business, government, labor and the nonprofit sector. Oregon's State and Local Workforce Investment Boards, which are organized as business-led partnerships, provide a "convening table" for labor, economic development, elected officials, education, workforce development and human service providers to create community-based solutions to today's and tomorrow's workforce challenges. The stated mission of these boards is to assure that:

- Oregonians have the skills they need to fill current and emerging high-wage, high-demand jobs.

- Employers have the skilled workforce they need to remain competitive and contribute to local prosperity.

- The workforce system is aligned, provides integrated services and makes efficient and effective use of resources to achieve better outcomes for businesses and job seekers.

In 2012, Oregon adopted a ten-year strategic plan developed by the Oregon Workforce Investment Board and developed a ten-year budget plan to better align resources, strategies and services for the new economy. This Executive Order initiates a process that will re-charter Oregon's State and Local Workforce Investment Boards to lead efforts to reduce fragmentation and align federal and state programs to better serve Oregon's job seekers and businesses in this new economy.

Re-chartering is based on the following principles:

1. Ultimately all solutions are local. The state sets the vision, invests in outcomes, and supports implementation with policies, resources and accountability structures; locals develop solutions that fit the needs of their communities to achieve the outcomes.

2. Convening tables that fully engage the private sector and attract a wide array of private and public partners and resources to achieve common outcomes are critical to the creation of workforce solutions.

3. Workforce solutions must achieve high value outcomes for any Oregonian who can and wants to work, for businesses, for communities and for the entire state.

4. The challenges of our new economy are urgent and resources are limited. Efficiencies must be found to achieve cost effective solutions that result in more Oregonians able to earn a good living and more businesses able to compete and grow in the new economy.

This Executive Order also charges those state agencies that administer workforce programs to work with the Governor, the Office of the Chief Operating Officer (also known as the Department of Administrative Services), legislators, the State and Local Workforce Investment Boards, and stakeholders to align Oregon's workforce system in light of reduced resources and the changing economy.

The effort to redesign Oregon's workforce system will complement, be informed by, and benefit from state investments to increase economic growth and reduce poverty, the efforts of Regional Solutions Committees throughout Oregon, and initiatives to expand educational achievement, commonly known as Oregon's 40-40-20 goals.

NOW THEREFORE, IT IS HEREBY DIRECTED AND ORDERED:

1. By June 30, 2015, Local Workforce Investment Boards will be re-chartered to:

a. Better direct public workforce investments at the state and local level for talent development, job creation, income progression, business competitiveness, integrated service delivery and expanded opportunities for citizen prosperity;

b. Use labor market intelligence to better align economic development, education and training, and workforce development investments and services for job seekers and businesses to efficiently address local labor market needs and statewide priorities;

c. Expand private-public partnerships with an integrated workforce system to better meet the needs of communities and create solutions to address tomorrow's workforce challenges;

d. Partner with the Governor's Regional Solutions Committees to identify and leverage opportunities to expand job creation and incent job growth; and

e. Be accountable for workforce system outcomes.

2. As part of the re-chartering process, Local Workforce Investment Boards will become neutral, independent brokers of workforce services, purchasing services from those equipped to deliver the best possible results by July 1, 2015.

3. By December 31, 2013, a process convened by the Governor's Office, staffed by the Office of the Chief Operating Officer, and engaging representatives of State and Local Workforce Investment Boards, State Agencies, Business, Organized Labor, Local Elected Officials and the Legislature will develop specific criteria and mechanisms to re-charter Local Workforce Investment Boards. Local Workforce Investment Boards must comply with the criteria by June 30, 2015.

4. The State Workforce Investment Board will be re-chartered to serve as independent advisory body to the Governor with designated staff by June 1, 2014 in order to:

a. Facilitate the provision of resources to support locally developed workforce solutions, and contingent on budget approvals, shall provide resources to local workforce boards;

b. Solicit local recommendations and work with state agencies to increase system alignment;

c. Monitor and evaluate the implementation of the strategic plan, making adjustments as needed based on a changing economy; and

d. In conjunction with local and statewide business partners, private foundations, and state agencies, the State Workforce Investment Board shall plan a statewide convening of the workforce system, employers and organized labor to report on results of ongoing efforts, examine effective strategies, celebrate success, and consider recommendations for continuing to enhance statewide alignment and innovation of workforce services.

5. By the end of 2013, in preparation for the 2014 Legislative Session, those state agencies that currently administer Oregon's workforce programs, in conjunction with the Office of the Chief Operating Officer, the Governor and the Legislature will develop a plan to better align the administrative infrastructure of the workforce system to support the work of the re-chartered boards. These state agencies will:

a. Develop a mechanism for funding the functions of the State and Local Workforce Investment Boards;

b. Direct resources to achieve agreed upon state and federal outcomes;

c. Align administrative infrastructure and data systems to support the workforce system;

d. Work together across programmatic silos to increase the alignment and integration of workforce programs;

e. Evaluate the cost-benefit of proposed actions; and

f. Develop a transparent and integrated workforce budget by 2015.

6. Publicly funded workforce programs delivered at the state and local level will work with Oregon's State and Local Workforce Investment Boards to avoid unnecessary duplications and make use of labor market intelligence to guide the delivery of services to job seekers and businesses and the development of new workforce solutions.

7. The Oregon Workforce Investment Board and the Oregon Education Investment Board will work together to identify ways to achieve common results across education and workforce systems.

8. In the event of a conflict between any provision of state or federal law and this Executive Order, state or federal law will prevail and the remaining terms of this Executive Order shall remain in force and effect.

Done at Salem, Oregon this 25th day of July, 2013.

/s/ John A. Kitzhaber
John A. Kitzhaber, M.D.
GOVERNOR

ATTEST

/s/ Kate Brown
Kate Brown
SECRETARY OF STATE

REQUEST FOR COMMENT
PROPOSED CONSENT ORDER FOR PROSPECTIVE PURCHASE AGREEMENT, ESQUIRE MOTORS SITE, MULTNOMAH COUNTY, OREGON

COMMENTS DUE: Aug. 30, 2013
PROJECT LOCATION: 1853 SW Jefferson St., Portland, Or
PROPOSAL: The Oregon Department of Environmental Quality proposes to enter a consent order for a Prospective Purchaser Agreement with Jefferson Holdings LLC for the Esquire Motors site property.
HIGHLIGHTS: The property, vacant for about a year and a half, was used primarily for various industrial/commercial operations for decades, most recently as an auto garage. The historical operations resulted in known or suspected soil, vapor and/or groundwater contaminants at the site including petroleum- and chlorinated solvent-related contamination. Following a soil removal action in 2012, DEQ issued a No Further Action Determination Addendum which included release by DEQ of an environmental Easement and Equitable Servitudes.

While significant cleanup activity has occurred, some contamination remains in soil and groundwater. These do not present an unacceptable risk but may require characterization and management as solid waste if encountered or generated during intrusive property development activities. DEQ's No Further Action document recommends but does not require that site development involving excavation or intrusive activities be conducted based on a site-specific, DEQ-approved contaminated media management plan.

Assuming completion of this consent order, Jefferson Holdings LLC plans to purchase the property from PHO Properties LLC and RRO Properties LLC. Jefferson Holdings LLC plans a residential, retail and/or office transit-oriented development near an existing MAX light-rail station.

Under the consent order, Jefferson Holdings LLC will record in the Multnomah County real property records an obligation to implement a contaminated media management plan with DEQ oversight. The contaminated media management plan will apply to intrusive development activities involving excavation, or intrusive development activities that may encounter or generate residual impacted soil and/or groundwater. Other DEQ-approved plans may be required by DEQ if Jefferson Holdings LLC elects to voluntarily remove contaminated media.

Jefferson Holdings LLC will have what the City of Portland calls a "pre-application conference" with the city to discuss the transit-oriented development plan in more detail within six months of acquiring the property. Jefferson Holdings LLC will also obtain a building permit for and begin construction of the development no later than 10 years after acquiring the property. The term "begin construction" has the meaning commonly applied by the city to commencement of sufficient work within 180 days of building permit issuance for the permit to remain valid under the present city code. DEQ may extend the time for those actions to take place. These actions may be satisfied by Jefferson Holdings LLC and/or its partners, successors, or assigns.

This prospective purchaser agreement provides a substantial public benefit because it will provide for implementation of a contaminated media management plan or other appropriate plan for proper characterization and management protocols for affected soil and water during intrusive development. This consent order fosters the intended purchase and enhanced productive reuse of the vacant property.

DEQ launched the prospective purchaser agreement program in 1995 through amendments to the state's environmental cleanup Law. A prospective purchase agreement is a tool that expedites cleanup of contaminated property and encourages property transactions that would otherwise not likely occur because of liabilities associated with purchasing a contaminated site.

This proposed consent order will provide Jefferson Holdings LLC a release from liability for claims by the State of Oregon under ORS 465.200 to 465.545 and 465.990, 466.640, and 468B.310 regarding existing hazardous substance releases at or from the property. The proposed consent order will also provide Jefferson Holdings LLC with third-party liability protection.
HOW TO COMMENT: The project file may be reviewed by appointment at DEQ's Northwest Region Portland Office, 2020 SW 4th Ave., Portland, OR 97201-4987. To schedule an appointment to review the file please contact Dawn Weinberger at (503) 2290-6729. Summary information and copies of documents referenced above are available in DEQ's Environmental Cleanup Site Information database on the Internet. To review this material, go to http://www.deq.state.or.us/lq/ECSI/ecsiquery.asp, then enter 4906 in the Site ID box and click "Submit" at the bottom of the page. Next, click the link labeled 4906 in the Site ID/Info column. To be considered, written comments should be sent to: Mark Pugh, DEQ Project Manager, at the address listed above, or by email at Pugh.Mark@deq.state.or.us by 5 p.m. Aug. 30, 2013. DEQ will hold a public meeting if it receives a written request by 10 or more persons or by a group with a membership of 10 or more.
NEXT STEP: DEQ will consider all public comments received by the date and time stated above before finalizing and issuing the consent order. A public notice of DEQ's final decision will be issued in this publication.
ACCESSIBILITY INFORMATION: DEQ is committed to accommodating people with disabilities. Please notify DEQ of any special physical or language accommodations or if you need information in large print, Braille or another format. To make these arrangements, contact DEQ's Office of Communications and Outreach, Portland, 503- 229-5696 or call toll free in Oregon at 800-452-4011; fax to 503-229-6762; or e-mail to deqinfo@deq.state.or.us. People with hearing impairments may call 711.

REQUEST FOR COMMENTS
PROPOSED CONSENT ORDER FOR PROSPECTIVE PURCHASER AGREEMENT AT THE FRANKO #6 SITE, LINCOLN COUNTY, OREGON

COMMENTS DUE: Aug. 30, 2013
PROJECT LOCATION: 906 US Highway 101 South in Lincoln City, Oregon.
PROPOSAL: Goodwill Industries is proposing to redevelop the property and six adjoining tax lots into a retail store and job connection center. Redevelopment will provide jobs during construction and upon completion. The new facility will employ from 35 to 48 full time positions and provide a no cost job placement service to area residents.

The site is approximately one-half acre and includes a gravel and soil surface with limited areas of asphalt. The property was the former location of the Franko #6 and Lincoln City Pride service and fuel dispensing stations. Petroleum contamination from gasoline, diesel, and heavy–oil has been observed on the property since at least 1988. Underground storage tank systems and fuels dispensers were removed in 1993.

Since the report of contamination and removal of the underground storage tank systems, several stages of site investigation have been completed. Soil and groundwater have been contaminated at multiple locations on the subject property. A network of groundwater monitoring wells has been installed to assess the level of contamination and track remedial progress. No surface water contamination has been reported.

Some cleanup has been completed including the installation of a vapor extraction system in the area of the former underground storage tank systems and excavation in the area of the dispenser island. The most recent site investigation included temporary borings on and off the subject property. Soil, groundwater and soil-gases were sampled to help in the development of remedies needed to facilitate the proposed reuse.

During redevelopment of this and the adjacent properties the following steps will be taken to address areas of contamination exceeding Oregon DEQ cleanup levels:

- No use of groundwater
- Protective cap over areas of contamination to prevent direct contact and help control migration.

• Vapor barriers as needed beneath buildings to prevent petroleum vapor migration into proposed structures.

• Defined on-site reuse of any contaminated soil removed during construction.

DEQ launched the prospective purchaser agreement program in 1995 through amendments to the state's environmental cleanup law. The prospective purchaser agreement is a tool that expedites cleanup of contaminated property and encourages property transactions that would otherwise not likely occur because of the liabilities associated with purchasing a contaminated site.

The proposed consent order will provide Goodwill Industries of the Columbia Willamette with a release from liability for claims by the State of Oregon under ORS 465.200 to 465.545 and 465.990, 466.640, and 468B.310 regarding existing hazardous substance releases at or from the property. The proposed consent order will also provide Goodwill Industries of the Columbia Willamette with third party liability protection.

HOW TO COMMENT: The project file may be reviewed by appointment at DEQ's Salem office at 750 Front St. NE, Suite120, Salem, OR 97301. To schedule an appointment to review the file or to ask questions, please contact Jim Glass at 503-378-5044. Summary information and copies of the documents referenced above are available in DEQ's Leaking Underground Storage Tanks database on the Internet. To review this material, go to http://www.deq.state.or.us/lq/tanks/lust/lustpubliclookup.asp, then enter 21-88-4088; in the LUST Number box and click "Lookup" at the bottom of the page. Next, click the link labeled 21-88-4088 in the "Log Number" column.

Send written comments to Jim Glass, at the address listed above or glass.jim@deq.state.or.us. Comments must be received by 5 p.m., Friday, Aug. 30th, 2013.

DEQ will hold a public meeting if it receives a written request by 10 or more people or by a group with a membership of 10 or more.

NEXT STEP: DEQ will consider all public comments received by the date and time stated above before making a final decision about the proposed remedial actions taken at the site. DEQ will issue a public notice of DEQ's final decision in this publication.

ACCESSIBILITY INFORMATION: DEQ is committed to accommodating people with disabilities. Please notify DEQ of any special physical or language accommodations or if you need information in large print, Braille or another format. To make these arrangements, contact DEQ Office of Communications and Outreach 503-229-5696 or toll free in Oregon at 800-452-4011; fax to 503-229-6762; or e-mail to deqinfo@deq.state.or.us.

People with hearing impairments may call 711.

FINALIZED CONSENT JUDGMENT FOR CANOE BAY CLEANUP

PROJECT LOCATION: Canoe Bay, North side of Hayden Island, Portland

DECISION: The Department of Environmental Quality has finalized a consent judgment with Inland Sea Maritime Group LLC and Schooner Creek Boat Works. The consent judgment will cover DEQ cleanup oversight of shoreline contamination cleanup and includes settlement of the parties' potential liability for contribution to sediment contamination in Canoe Bay. The consent judgment also documents satisfaction of liability associated with State of Oregon natural resource damages for Canoe Bay.

HIGHLIGHTS: Canoe Bay is a 7.6-acre rectangular inlet off the Columbia River located on the central north side of Hayden Island. Inland Sea Maritime Group owns approximately 6 acres of upland land on the southwestern edge of the bay. Schooner Creek Boat Works leases a portion of the upland property on which it operates a boat maintenance, repair, and new construction facility.

DEQ issued a record of decision for cleanup of shoreline contamination associated with the debris pile and stormwater outfall in August 2012. The cleanup action will include capping and stabilizing the shoreline contamination areas.

PUBLIC REVIEW: The draft consent judgment was made available for public review in September 2012. No comments were received. View the final consent judgment at http://www.deq.state.or.us/Webdocs/Forms/Output/FPController.ashx?SourceId=3333&SourceIdType=11 or at the DEQ Northwest Region Office in Portland. To schedule an appointment to review files in DEQ's Northwest Region office, call 503-229-6729. For more information on the project contact Jennifer at 503 229-6148 or sutter.jennifer@deq.state.or.us.

THE NEXT STEP: Consultants for Inland Sea Maritime Group and Schooner Creek Boat Works are preparing remedial action work documents. Implementation is planned to begin in August 2013.

ACCESSIBILITY INFORMATION: DEQ is committed to accommodating people with disabilities. Please notify DEQ of any special physical or language accommodations or if you need information in large print, Braille or another format. To make these arrangements, contact DEQ Communications and Outreach 503-229-5696 or toll free in Oregon at 800-452-4011; fax to 503-229-6762; or email to deqinfo@deq.state.or.us.

People with hearing impairments may call 711.

REQUEST FOR COMMENTS PROPOSED SETTLEMENT AND CONSENT JUDGMENT FOR THE PACIFIC CARBIDE & ALLOYS COMPANY SITE

COMMENTS DUE: 5 p.m., Friday, Aug. 30, 2013

PROJECT LOCATION: 9901 North Hurst Ave., Portland

PROPOSAL: The Oregon Department of Environmental Quality invites comments on its proposal to enter into a settlement with Pacific Carbide & Alloys Co. The settlement, in the form of a consent judgment, concerns potential cleanup liability related to its property, including contaminated sediments in the Columbia Slough.

The settlement would require Pacific Carbide to pay $400,000 to a DEQ-administered account dedicated to investigation and cleanup of bank soil and sediment contamination in the Columbia Slough. Pacific Carbide also would settle potential natural resource damage claims by paying $50,000 to a DEQ-administered account dedicated to habitat restoration within the Columbia Slough watershed. In return, Pacific Carbide would receive a covenant not to sue from the State of Oregon and contribution protection from claims by third parties relating to historic releases to the Slough and the Pacific Carbide site. The liability releases and contribution protection would be after the company pays the settlement amounts and completes the upland cleanup under terms of the consent judgment.

HIGHLIGHTS: The 16-acre property was developed in the 1940s and operated as a calcium carbide manufacturing plant until 1987. Calcium hydroxide, generally referred to as lime, was a by-product generated during this process and was stockpiled at the site. Significant amounts of lime entered the Columbia Slough through direct discharges from a settling pond and during a catastrophic dike failure in the 1970s. The lime is associated with elevated pH, elevated levels of polycyclic aromatic hydrocarbons, referred to as PAHs, and metals.

Between 2003 and 2006 Pacific Carbide completed a remedial investigation. Following a public comment period, DEQ issued a Record of Decision in 2007 that identified remedial actions to address site contamination. These actions included removing remaining lime stored at the site, from the Columbia Slough and slough bank, and capping residual contamination in the upland area. Most of the remaining above-grade lime was removed in 2007 under a DEQ Consent Order. Subsequent sediment and upland soil sampling, and observations during the lime pile removal, showed more extensive by-product lime impacts than prior investigations had indicated. Due to the associated increase in cleanup costs, Pacific Carbide indicated they did not have sufficient funds to complete the required work.

Under terms of the consent judgment, the money payments would complete Pacific Carbide's obligation for the bank soil, slough sediment and natural resources damages. Pacific Carbide would con-

tinue to complete the upland remedy, which includes grading and installing an engineered cap over residual contamination, operating and maintaining the cap, and implementation of institutional controls through an Easement and Equitable Servitudes recorded with Multnomah County.

The cap would prevent direct contact of site workers with contaminated soil, mitigate potential future contaminant contributions to the Columbia Slough from stormwater runoff, and allow expanded use of the facility.

HOW TO COMMENT: To schedule an appointment to review files in DEQ's Northwest Region office, call 503-229-6729. Send comments on the draft consent judgment by 5 p.m., Friday, Aug. 30, 2013 to DEQ Project Manager, Mark Pugh, DEQ Northwest Region, 2020 SW 4th Ave., Portland, OR 97201 or pugh.mark@deq.state.or.us. For more information contact Pugh at 503 229-5587.

THE NEXT STEP: DEQ will review and consider all comments received during the comment period. If DEQ decides to enter the consent judgment, it will be executed by the parties and then filed with the Multnomah County Circuit Court. The court must approve the consent judgment for it to take effect.

ACCESSIBILITY INFORMATION: DEQ is committed to accommodating people with disabilities. Please notify DEQ of any special physical or language accommodations or if you need information in large print, Braille or another format. To make these arrangements, contact DEQ Communications and Outreach 503-229-5696 or toll free in Oregon at 800-452-4011; fax to 503-229-6762; or email to deqinfo@deq.state.or.us.

People with hearing impairments may call 711.

Notices of Proposed Rulemaking and Proposed Rulemaking Hearings

The following agencies provide Notice of Proposed Rulemaking to offer interested parties reasonable opportunity to submit data or views on proposed rulemaking activity. To expedite the rulemaking process, many agencies have set the time and place for a hearing in the notice. Copies of rulemaking materials may be obtained from the Rules Coordinator at the address and telephone number indicated.

Public comment may be submitted in writing directly to an agency or presented orally at the rulemaking hearing. Written comment must be submitted to an agency by 5:00 p.m. on the Last Day for Comment listed, unless a different time of day is specified. Oral comments may be submitted at the appropriate time during a rulemaking hearing as outlined in OAR 137-001-0030.

Agencies providing notice request public comment on whether other options should be considered for achieving a proposed administrative rule's substantive goals while reducing negative economic impact of the rule on business.

In Notices of Proposed Rulemaking where no hearing has been set, a hearing may be requested by 10 or more people or by an association with 10 or more members. Agencies must receive requests for a public rulemaking hearing in writing within 21 days following notice publication in the *Oregon Bulletin* or 28 days from the date notice was sent to people on the agency mailing list, whichever is later. If sufficient hearing requests are received by an agency, notice of the date and time of the rulemaking hearing must be published in the *Oregon Bulletin* at least 14 days before the hearing.

**Auxiliary aids for persons with disabilities are available upon advance request*. Contact the agency Rules Coordinator listed in the notice information.

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Board of Examiners for Engineering and Land Surveying
Chapter 820

Rule Caption: Amend rules related to applications, digital signatures, and public record requests. Repeal one rule.

Date:	**Time:**	**Location:**
9-10-13	1:30 p.m.	670 Hawthorne Ave., SE Suite 220 Salem, OR 97301

Hearing Officer: Carl Tappert
Stat. Auth.: ORS 672.255
Other Auth.: ORS 670.310
Stats. Implemented: ORS 672.002–672.325
Proposed Amendments: 820-001-0020, 820-010-0010, 820-010-0227, 820-010-0228, 820-010-0305, 820-010-0442, 820-010-0620, 820-010-0621
Proposed Repeals: 820-010-0260
Last Date for Comment: 9-10-13, Close of Hearing
Summary: OAR 820-001-0020 — Update the methods and process in which the public may request records. Language is more consistent with the Oregon Public Records Law (SB 554, 2007 Legislation).

OAR 820-010-0010 — Adds language to define "Certificate Authority" and "Digital Certificate" used in OAR 820-010-0620.

OAR 820-010-0227 — Decreases the fee for an initial FE examination application to $0.00.

OAR 820-010-0228 — Decreases the fee for an initial FLS examination application to $0.00.

OAR 820-010-0305 — Decreases the fees for an initial application and an application for reexamination to the FE and FLS examinations to $0.00.

OAR 820-010-0442 — Housekeeping. Removes language regarding a process that is not statutorily required. However, the process does currently allow applicants one additional opportunity to submit any lacking documentation by a secondary deadline. If documents are not received, the application package will be incomplete and the application will be considered withdrawn.

OAR 820-010-0620 — Clarifies the requirements of a digital signature.

OAR 820-010-0621 — Changes the "will" to a "must"; the original intent of the Board.

OAR 820-010-0260 — Repeal. The Board follows the requirements contained in ORS 183 and the Administrative Procedures Act (APA) with regard to providing notice and hearing rights.
Rules Coordinator: Mari Lopez
Address: Board of Examiners for Engineering and Land Surveying, 670 Hawthorne Ave. SE, Suite 220, Salem, OR 97301
Telephone: (503) 362-2666, ext. 26

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Board of Pharmacy
Chapter 855

Rule Caption: Implements temporary revenue surplus reduction pursuant to ORS 291.055(3) for certain licensure fees.
Stat. Auth.: ORS 689.205, 475.095 & 291.055
Other Auth.: 2013 HB 5036
Stats. Implemented: ORS 689.135, 431.972 & 689.774
Proposed Amendments: 855-110-0005, 855-110-0007, 855-110-0010
Last Date for Comment: 8-30-13, 4:30 p.m.
Summary: These proposed rules implement revenue surplus reductions pursuant to ORS 291.055(3) for certain licensing fees as approved in the Board's 2013-15 Legislatively Approved Budget. The following fees are included: Pharmacist, Reciprocity, County Health Clinics, Family Planning Clinics, Hospital Drug Rooms, Correctional Facilities, Prophylactic/Contraceptive Outlets, Retail and Institutional Drug Outlets, Home Dialysis Drug Outlets and all Controlled Substance registration fees. Copies of the full text of these rules can be obtained on the Board's website at www.pharmacy.state.or.us, or by calling the Board office (971) 673-0001.
Rules Coordinator: Karen MacLean
Address: Board of Pharmacy, 800 NE Oregon St., # 150, Portland, OR 97232
Telephone: (971) 673-0001

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Board of Psychologist Examiners
Chapter 858

Rule Caption: Repeals the applied psychology track to psychologist licensure.
Stat. Auth.: ORS 675.010–675.150
Stats. Implemented: ORS 675.030 & 675.110
Proposed Amendments: 858-010-0001, 858-010-0010, 858-010-0012, 858-010-0013, 858-010-0016, 858-010-0017, 858-010-0036
Proposed Repeals: 858-010-0011
Last Date for Comment: 9-6-13, 5 p.m.
Summary: The proposed amendment repeals the applied psychology educational requirements and all references to the "applied track" to licensure as a psychologist.
Rules Coordinator: LaReé Felton
Address: Board of Psychologist Examiners, 3218 Pringle Rd. SE, Suite 130, Salem, OR 97302
Telephone: (503) 373-1196

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Rule Caption: Modifies definitions, application procedure, inactive status, and supervised work experience requirements.
Stat. Auth.: ORS 675.010–675.150
Stats. Implemented: ORS 675.030, 675.045, 675.070 & 675.110
Proposed Amendments: 858-010-0001, 858-010-0005, 858-010-0012, 858-010-0013, 858-010-0017, 858-010-0020, 858-010-0025, 858-010-0030, 858-010-0036, 858-010-0037, 858-010-0050, 858-010-0060, 858-010-0080, 858-020-0015, 858-020-0025, 858-020-0035, 858-020-0045, 858-020-0055, 858-020-0085, 858-020-0105, 858-030-0005
Last Date for Comment: 9-6-13, 5 p.m.

Summary: The proposed amendment reorganizes and adds general definitions; makes various clarifying language and grammar housekeeping changes; makes some clarifying changes to the supervised work experience requirements; creates a retention period of three years for a residency supervisor's records and notes; adds a requirement that the residency supervisor notify the board within fourteen days of any significant interruption or expected termination of a resident supervision contract; modifies and adds definitions to the process for application review; updates the examination procedures; adds a clear definition of inactive status; specifies that a license will revert to inactive status if a licensee fails to pay the prorated reactivation fee in 30 days.
Rules Coordinator: LaReé Felton
Address: Board of Psychologist Examiners, 3218 Pringle Rd. SE, Suite 130, Salem, OR 97302
Telephone: (503) 373-1196

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Department of Consumer and Business Services, Building Codes Division
Chapter 918

Rule Caption: Adopts 2014 Oregon Structural Specialty Code and clarifies scope and authority of state building code

Date:	Time:	Location:
8-20-13	9:30 a.m.	1535 Edgewater St. NW Salem, OR 97304

Hearing Officer: Steven Judson
Stat. Auth.: ORS 447.020, 447.231, 447.247, 455.020, 455.030, 455.110, 455.447 & 479.730
Stats. Implemented: ORS 447.020, 447.247, 455.110, 455.112 & 479.730
Proposed Adoptions: Rules in 918-460
Proposed Amendments: Rules in 918-460, 918-008
Proposed Repeals: Rules in 918-460
Last Date for Comment: 8-23-13, 5 p.m.
Summary: The proposed rules adopt the 2012 edition of the International Building Code with Oregon amendments and shall be known as the 2014 Oregon Structural Specialty Code (OSSC). The proposed rules also update the amendments made to the 2010 OSSC by incorporating them into the 2014 OSSC. The proposed rules also establish a phase-in period that requires all municipal building inspection program to allow the choice of using the 2010 OSSC or the 2014 OSSC. Additionally, these rules clarify the scope and authority of the state building code.
Rules Coordinator: Richard J. Baumann
Address: Department of Consumer and Business Services, Building Codes Division, PO Box 14470, Salem, OR 97309-0404
Telephone: (503) 373-7559

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Rule Caption: Adopts the 2014 Oregon Mechanical Specialty Code.

Date:	Time:	Location:
8-20-13	10 a.m.	1535 Edgewater Street NW Salem, OR 97304

Hearing Officer: Mark Heizer
Stat. Auth.: ORS 455.020, 455.030 & 455.110
Stats. Implemented: ORS 455.110
Proposed Adoptions: Rules in 918-440
Proposed Amendments: Rules in 918-440
Proposed Repeals: Rules in 918-440
Last Date for Comment: 8-23-13, 5 p.m.
Summary: The proposed rules adopt the 2012 Editions of the International Mechanical Code and the International Fuel Gas Code with Oregon amendments and shall be known as the 2014 Oregon Mechanical Specialty Code (OMSC). The proposed rules also update the amendments made to the 2010 OMSC by incorporating them into the 2014 OMSC. The proposed rules also establish a phase-in period that requires all municipal building inspection program to allow the choice of using the 2010 OMSC or the 2014 OMSC.
Rules Coordinator: Richard J. Baumann
Address: Department of Consumer and Business Services, Building Codes Division, PO Box 14470, Salem, OR 97309-0404
Telephone: (503) 373-7559

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Rule Caption: Adopts the 2014 Oregon Energy Efficiency Specialty Code

Date:	Time:	Location:
8-20-13	9 a.m.	1535 Edgewater Street NW Salem, OR 97304

Hearing Officer: Mark Heizer
Stat. Auth.: ORS 455.020, 455.030, 455.110, 455.505 & 455.511
Stats. Implemented: ORS 455.110 & 455.511
Proposed Adoptions: Rules in 918-460
Proposed Amendments: Rules in 918-460
Proposed Repeals: Rules in 918-460
Last Date for Comment: 8-23-13, 5 p.m.
Summary: The proposed rules adopt the 2014 Edition of the Oregon Energy Efficiency Specialty Code (OEESC). The 2014 OEESC is based upon the 2010 OEESC with Oregon amendments. The proposed rules update the amendments made to the 2010 OEESC by incorporating them into the 2014 OEESC. The proposed rules also establish a phase-in period that requires all municipal building inspection programs to allow the choice of using the 2010 OEESC or the 2014 OEESC.
Rules Coordinator: Richard J. Baumann
Address: Department of Consumer and Business Services, Building Codes Division, PO Box 14470, Salem, OR 97309-0404
Telephone: (503) 373-7559

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Department of Consumer and Business Services, Workers' Compensation Board
Chapter 438

Rule Caption: Adopting OAR 438-011-0055, which requires "paying agency" to issue a "third party election" letter.

Date:	Time:	Location:
9-6-13	10 a.m.	2601 25th St. SE, Suite 150 Salem, OR 97302

Hearing Officer: Debra L. Young
Stat. Auth.: ORS 656.726(5)
Stats. Implemented: ORS 656.576, 656.578, 656.580, 656.583, 656.587, 656.591 & 656.593
Proposed Adoptions: 438-011-0055
Last Date for Comment: 9-6-13, 5 p.m.
Summary: The Board proposes to adopt OAR 438-011-0055 to require a carrier ("paying agency") to serve a written demand ("third party election" letter) on the claimant/beneficiaries/legal representative ("the claimant") if the paying agency intends to require the claimant to exercise the right of election in ORS 656.578 to recover damages from a noncomplying employer or third person ("third party"). See Section (1). The "paying agency" shall include with this "third party election" letter a separate enclosure prescribed by Board bulletin that explains the "third party election/assignment" process. See Section (2). If the claimant does not read or understand English, or is otherwise unable to understand written language, the paying agency shall provide this information in a language or other manner that ensures understanding. Id. Section (3) provides that the "third party election" letter must: (a) contain the information prescribed by ORS 656.583; and (b) include a statement that the claimant has been provided with the informational enclosure prescribed by Board bulletin in section (2).
Rules Coordinator: Karen Burton
Address: Department of Consumer and Business Services, Workers' Compensation Board, 2601 25th St. SE, Suite 150, Salem, OR 97302
Telephone: (503) 934-0123

Department of Energy,
Energy Facility Siting Council
Chapter 345

Rule Caption: Amend CO2 Emissions Standard and CO2 Offset Standard for Power Plants
Stat. Auth.: ORS 469.470 & 469.503
Stats. Implemented: ORS 469.501 & 469.503
Proposed Amendments: 345-024-0550, 345-024-0590
Last Date for Comment: 9-6-13, 5 p.m.
Summary: Carbon Dioxide Standard for Non-Base Load Power Plants

Rule amendments are proposed to amend OAR 345-024-0590(5) Carbon Dioxide Standard for Non-Base Load Power Plants. The proposed amendments will restore language that was unintentionally removed by rule amendments that were adopted in May 2012.

Rule amendments were initially proposed pursuant to a petition submitted by Portland General Electric (PGE) on July 22, 2009. The proposed rule amendments provided an alternate means of measuring "actual gross carbon dioxide emissions" every five years during the operation of a non-base load power plant. Those rule amendments allowed a certificate holder for a non-base load power plant to report actual carbon dioxide emissions consistent with any mandatory carbon dioxide emissions reported required by either the Oregon Department of Environmental Quality or the United States Environmental Protection Agency. After a rulemaking process, the Council adopted amendments to OAR 345-024-0590(5) on November 20, 2009. Those rule amendments remained in effect until May 2012 when the language was unintentionally removed with the new rule amendments that were adopted. The proposed amendments will restore the language that was unintentionally removed in May 2012.

Carbon Dioxide Offset Standard for Power Plants

Rule amendments are proposed to amend OAR 345-024-0550(2) standard for base load gas plants and OAR 345-024-0590(2) standard for non-base load power plants. The proposed rule amendments are needed in order to be consistent with new international standards. The United States Environmental Protection Agency is currently amending its rules to update the standards. The amount of greenhouse gas emissions means the pounds of carbon dioxide and the carbon dioxide equivalent of other greenhouse gases. The proposed standard would increase the standard for methane so that one pound of methane is equivalent to 25 pounds of carbon dioxide, and for nitrous oxide so that one pound of nitrous oxide is equivalent to 298 pounds of carbon dioxide.
Rules Coordinator: Lee Willeman
Address: Department of Energy, Energy Facility Siting Council, 625 Marion St. NE , Salem, OR 97301
Telephone: (503) 373-0214

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Department of Environmental Quality
Chapter 340

Rule Caption: Increase water quality permit fees to address program costs

Date:	Time:	Location:
8-20-13	6 p.m.	DEQ, 811 SW Sixth Ave. Portland, OR 97204

Hearing Officer: DEQ staff
Stat. Auth.: ORS 454.625, 468.020 & 468.065
Stats. Implemented: ORS 454.745, 454.755, 468.065, 468B.035, 468B.050, 468B.051 & 468B.195
Proposed Amendments: 340-045-0075, 340-071-0140
Last Date for Comment: 8-23-13, 5 p.m.
Summary: DEQ proposes increasing most water quality permit fees by 2.9 percent.

In 2002, DEQ convened the Blue Ribbon Committee on Wastewater Permitting to recommend improvements to DEQ's water quality permit program. The committee included industry, environmental and local government representatives. In 2004, the committee published a report containing a variety of recommendations, including increasing fee revenue by no more than 3 percent each year to address increasing program costs. The annual fee increase recommendation was adopted into law in 2005. To address increasing program costs, DEQ implemented fee increases in 2007, 2008, 2010, 2011 and 2012 and proposes this 2013 permit fee increase of 2.9 percent.
Rules Coordinator: Maggie Vandehey
Address: Department of Environmental Quality, 811 SW Sixth Ave., Portland, OR 97204-1390
Telephone: (503) 229-6878

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Rule Caption: Updates to Oregon SIP for Nitrogen Dioxide, Sulfur Dioxide and Lead Ambient Air Quality Standards

Date:	Time:	Location:
8-15-13	6 p.m.	DEQ Headquarters Conference Rm. B 811 SW Sixth Ave. Portland, OR 97204

Hearing Officer: DEQ staff
Stat. Auth.: ORS 468 & 468A
Stats. Implemented: ORS 468A
Proposed Amendments: 340-200-0020, 340-200-0040, 340-202-0070, 340-202-0100, 340-202-0130
Last Date for Comment: 8-19-13, 5 p.m.
Summary: The proposed rule amendments incorporate new and revised NAAQS for NO2, SO2 and Pbinto Oregon Administrative Rule and adopt significant air quality impact levels for NO2 and SO2 as necessary to meet Clean Air Act requirements and revise the Oregon SIP for approval by EPA. The proposal includes the following actions:

Amend OAR 340-200-0040 to update the Oregon Clean Air Act State Implementation Plan. If adopted by the EQC, the actions proposed in this rulemaking will be incorporated into and made part of Oregon SIP.

Amend OAR 340-200-0020 Table 1 to add 1-hour Significant Air Quality Impact Levels for NO2 and SO2.

Amend OAR 340-202-0070 to incorporate the primary 1-hour National Ambient Air Quality Standard for sulfur dioxide, adopted by the EPA June 22, 2010 and effective on August 23, 2010.

Amend OAR 340-202-0100 to incorporate the primary 1-hour National Ambient Air Quality Standard for nitrogen dioxide, adopted by the EPA February 9, 2010 and effective on April 12, 2010.

Amend OAR 340-202-0130 to incorporate the primary and secondary National Ambient Air Quality Standard for lead, adopted by the EPA November 12, 2008 and effective on January 12, 2009.
Rules Coordinator: Maggie Vandehey
Address: Department of Environmental Quality, 811 SW Sixth Ave., Portland, OR 97204-1390
Telephone: (503) 229-6878

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Rule Caption: Portland Area Transportation Control Measure

Date:	Time:	Location:
8-15-13	7 p.m.	DEQ Headquarters, EQC Rm. A, Floor 10 811 SW Sixth Ave. Portland, OR 97204

Hearing Officer: DEQ Staff
Stat. Auth.: ORS 468.020
Stats. Implemented: ORS 468A.035
Proposed Amendments: 340-200-0040
Last Date for Comment: 8-19-13, 5 p.m.
Summary: DEQ proposes to modify a "transportation control measure" that requires transit service in the Portland area to be expanded one percent per year. This proposal changes the transportation control measure to be assessed as a cumulative average over the life of the Portland area's plan to improve air quality instead of a five-year rolling average. This change in the transit transportation control measure averaging approach is proposed as a revision to the State

of Oregon Clean Air Act Implementation Plan, and will be submitted to the Environmental Protection Agency. Once adopted by the Environmental Quality Commission and with the concurrence of EPA and Metro the substitute transportation control measure becomes, by operation of law under 42 USC § 7506(c)(8), part of the State Implementation Plan and will be federally enforceable. U.S. EPA will not conduct a separate public notice process. Anyone who wishes to comment on EPA's concurrence with this action should do so during this comment period.

Note: For the purpose of Oregon rulemaking this is an amendment of the State of Oregon Clean Air Act Implementation Plan. Once adopted, the substitute transportation control measure becomes, by operation of law, part of the State Implementation Plan and becomes federally enforceable. U.S. EPA will not conduct a separate public notice process. Anyone who wishes to comment on EPA's concurrence with this action should do so during this comment period.

Rules Coordinator: Maggie Vandehey

Address: Department of Environmental Quality, 811 SW Sixth Ave., Portland, OR 97204-1390

Telephone: (503) 229-6878

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Department of Human Services,
Aging and People with Disabilities and
Developmental Disabilities
Chapter 411

Rule Caption: Adult Foster Homes For Adults Who Are Older Or Physically Disabled

Date:	**Time:**	**Location:**
8-20-13	2 p.m.	500 Summer St. NE, Rm. 160 Salem, OR 97301

Hearing Officer: Staff

Stat. Auth.: ORS 410.070, 443.001, 443.004, 443.725, 443.730, 443.735, 443.738, 443.742, 443.760, 443.767, 443.775 & 443.790

Other Auth.: 42 CFR 455 & 489, ORS 124.050, 124.060, 124.075, 127.520, 181.537, 430.735, 443.004, 443.880 & 197.660–197.670

Stats. Implemented: ORS 443.001–443.004, 443.705–443.825, 443.875 & 443.991

Proposed Adoptions: 411-050-0662

Proposed Repeals: 411-050-0490

Proposed Ren. & Amends: 411-050-0401 to 411-050-0600, 411-050-0400 to 411-050-0602, 411-050-0405 to 411-050-0605, 411-050-0410 to 411-050-0610, 411-050-0435 to 411-050-0615, 411-050-0412 to 411-050-0620, 411-050-0440 to 411-050-0625, 411-050-0443 to 411-050-0630, 411-050-0408 to 411-050-0632, 411-050-0415 to 411-050-0635, 411-050-0420 to 411-050-0640, 411-050-0430 to 411-050-0642, 411-050-0444 to 411-050-0645, 411-050-0445 to 411-050-0650, 411-050-0447 to 411-050-0655, 411-050-0491 to 411-050-0660, 411-050-0455 to 411-050-0665, 411-050-0450 to 411-050-0670, 411-050-0460 to 411-050-0675, 411-050-0465 to 411-050-0680, 411-050-0487 to 411-050-0685, 411-050-0483 to 411-050-0686, 411-050-0480 to 411-050-0687, 411-050-0481 to 411-050-0688, 411-050-0485 to 411-050-0690

Last Date for Comment: 8-22-13, 5 p.m.

Summary: The Department of Human Services (Department) is proposing to update the rules in OAR chapter 411, division 050 governing the licensure of adult foster homes for adults who are older or physically disabled (APD/AFH).

The proposed rules:

-Make permanent the May 23, 2013 emergency rule changes to no longer accept new applications for relative adult foster homes and transition individuals receiving services in relative adult foster homes to Medicaid in-home services because payments for relative adult foster home services can't be paid through the Medicaid system in the new State Plan option;

-Comply with 42 CFR 455 and 489 by clarifying Medicaid Provider Enrollment Agreements and the circumstances for denial or termination of enrollment and the service requirements for residents who are or become eligible for Medicaid services, specifying that any providers may not be listed on the Office of Inspector General's or General Services Administration's Exclusion Lists, defining ownership interest and indirect ownership interest, updating house policies and procedures concerning Advance Directives to include any limitations to the implementation of Advance Directives on the basis of conscience, and clarifying Centers for Medicare and Medicaid Services (CMS) access to adult foster homes and facility and resident records;

-Improve resident safety by including emergency preparedness planning, requiring carbon monoxide alarms, requiring an applicant to provide proof of CPR and First Aid certification as part of the initial application process, requiring substitute caregivers obtain CPR and First Aid certification within 30 days of employment, requiring medication administration training within the first year of licensure, and requiring that the bedroom for a licensee, resident manager, shift caregiver, and substitute caregiver be located in the home and have direct access to the residents through an interior hallway or common use room;

-Improve safety for residents requiring mechanical ventilation by clarifying the application, qualifications, training, classification, capacity requirements, and the operational and facility standards for homes providing ventilator-assisted care including requiring that a home that was approved to provide ventilator-assisted care prior to August 1, 2013 install a functional whole-home sprinkler system no later than July 31, 2015;

-Clarify the application, qualifications, training, construction, and facility and operational standards in limited license homes to improve safety for residents;

-Expand the limited options of provisional licensing;

-Comply with Oregon Fire Code requirements related to fire and life safety which improves resident and occupant safety by clarifying use of portable heaters, use of relocatable power taps, and storage of gas cylinders; and

-Comply with the requirements outlined in Oregon Revised Statute 305.385.

In addition, the Department is proposing to reorganize, clarify, and provide consistent language to reflect current practices, improve readability, and establish consistency with other Department rules. The proposed rules provide clarification on —

-Qualification and training requirements for applicants, licensees, resident managers, substitute caregivers, back-up providers, and other caregivers including having a licensee provide orientation of the home prior to a caregiver providing services;

-Financial information required by an applicant or licensee;

-License renewal requirements;

-Procedures for changing the classification or capacity of a home;

-Information requested for room and board tenants;

-Operational standards for a home including standards relating to staffing, the absence of a primary caregiver, foreclosure, house policies, and mandatory written notice of an involuntary move or transfer;

-Home and safety standards including the visibility of a home's address, non-municipal water testing, emergency exits, evacuation drills, and safety standards for bathrooms, bedrooms, and combustibles; and

-Standards and practices for care and enrollment including contracts, Medicaid enrollment status, long-term care assessment, hospice services, medication availability, medication order reviews, psychoactive medication evaluations, storage of resident and non-resident medications, physical restraint assessment and documentation of restraint, and screening and information required for individuals admitted for day care.

Rules Coordinator: Christina Hartman

Address: Department of Human Services, Aging and People with Disabilities and Developmental Disabilities, 500 Summer St. NE, E-10, Salem, OR 97301-1074

Telephone: (503) 945-6398

Department of Human Services,
Self-Sufficiency Programs
Chapter 461

Rule Caption: Changing OARs affecting public assistance, medical assistance, or Supplemental Nutrition Assistance Program clients

Date:	Time:	Location:
8-21-13	9:30 a.m.	500 Summer St. NE, Rm. 257 Salem, OR

Hearing Officer: Annette Tesch
Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.081, 411.095, 411.103, 411.116, 411.400, 411.404, 411.408, 411.660, 411.706, 411.710, 411.816, 411.837, 411.840, 411.892, 412.001, 412.006, 412.009, 412.014, 412.049, 412.124, 414.231 & 2011 OL 604
Other Auth.: 42 USC 602(a), 7 USC 2014, 42 CFR 435.910, 45 CFR 98, 7 CFR 273.9(d)(6)(iii), 7 CFR 273.5(b)(6) & 7 CFR 271.2
Stats. Implemented: ORS 409.010, 409.050, 409.610, 411.060, 411.070, 411.081, 411.087, 411.095, 411.103, 411.116, 411.117, 411.121, 411.122, 411.135, 411.400, 411.404, 411.408, 411.620, 411.630, 411.635, 411.640, 411.660, 411.690, 411.704, 411.706, 411.710, 411.816, 411.825, 411.837, 411.840, 411.892, 412.001, 412.006, 412.009, 412.014, 412.049, 412.069, 412.124, 414.025, 414.231, 414.826, 414.831, 414.839, 416.350 & 2011 OL 604
Proposed Amendments: 461-001-0000, 461-025-0310, 461-110-0370, 461-110-0430, 461-120-0210, 461-130-0310, 461-135-0010, 461-135-0405, 461-135-0407, 461-135-0570, 461-135-0920, 461-135-0930, 461-150-0060, 461-155-0190, 461-160-0010, 461-160-0420, 461-160-0430, 461-170-0011, 461-190-0211, 461-195-0501, 461-195-0541, 461-195-0601, 461-195-0621
Proposed Repeals: 461-110-0430(T), 461-120-0210(T), 461-135-0407(T), 461-135-0570(T), 461-160-0010(T), 461-190-0211(T), 461-195-0501(T), 461-195-0541(T), 461-195-0601(T), 461-195-0621(T)
Last Date for Comment: 8-23-13, 5 p.m.
Summary: OAR 461-001-0000 about definitions for Chapter 461 is being amended to clarify the definitions of "parent" and "spouse" for the SNAP program and the definition of "household members" and "family members" under the definition of domestic violence.

OAR 461-025-0310 about hearing requests is being amended to clarify what constitutes good cause for a late hearing request, to clarify and correct the rule text about how late overpayment hearing requests are treated, and to place additional limits on when the Department may dismiss hearing requests that are less than 120 days late.

OAR 461-110-0370 about filing groups, 461-155-0190 about income and payment standards, and 461-160-0430 about income deductions are being amended to implement the annual increase in the standards for the SNAP Program. OAR 461-160-0420 is being amended to reflect the annual change in the Standard Utility Allowances. Each year Oregon surveys utility companies and the general public about increases in utility costs. The utility allowances are derived from these surveys and approved by the Food and Nutrition Service in the SNAP Program State Plan. There are four utility allowances. The full utility allowance (FUA) is for those households that have heating and cooling costs. The limited utility allowance (LUA) is for those households with more than one non-heating/cooling utility cost. The individual utility allowance (IUA) is for those households with a single non-heat cost. The single utility allowance (TUA) is for those households with only a telephone cost.

OAR 461-110-0430 about filing groups is being amended to make permanent temporary rule changes adopted April 10, 2013 and further revise which individuals are considered part of the filing group to determine eligibility in the Refugee and Refugee Medical programs. These filing groups identify the group of individuals whose combined circumstances are considered in making an eligibility determination.

OAR 461-120-0210 is being amended to make permanent a temporary rule change effective May 29, 2013 that added an exception to the requirement to provide or apply for a social security number for various medical programs (CCM, CEC, CEM, EXT, HKC, MAA, MAF, OHP, OSIPM, QMB and SAC) for individuals who do not have an SSN and may only be issued an SSN for a valid non-work reason.

OAR 461-130-0310 about the participation classifications is being amended to allow SNAP clients in receipt of REF or TANF program benefits to be exempt from SNAP employment program (OFSET) participation requirements (and disqualification) without being required to be in JOBS or NAES. This rule is also being amended to add exemptions for individuals who are in at least one of the following Employment Department training programs: 1) The Trade Readjustment Allowance (TRA) program serving displaced workers under the Trade Act; 2) The Training Unemployment Insurance (TUI) program; 3) The Self-Employment Insurance (SEA) program; 4) The Apprenticeship Program (APT).

OAR 461-135-0010 about assumed eligibility for medical programs is being amended to remove Refugee Medical (REFM) from the list of programs that have assumed eligibility. Assumed eligibility is a Medicaid term. REFM is not Medicaid. The relevant REFM eligibility policy will be covered instead in OAR 461-135-0930.

OAR 461-135-0405 about clients in the Employment Related Day Care (ERDC) program receiving child care under a contract between a Head Start program and the Department is being amended to adjust the protected eligibility requirements. Under this amendment, protected eligibility is expanded to include caretakers who become self-employed or students who are continuing to actively seek employment during the hours the Head Start child care program is operating and are available to work during the operating hours of the Head Start provider. This amendment also extends protected eligibility to caretakers whose loss of employment meets good cause criteria. Under this amendment, protected eligibility for the child will not cover child care when the child no longer attends a Head Start provider.

OAR 461-135-0407 about child care in the Employment Related Day Care (ERDC) program provided under a contract between an Oregon Program of Quality (OPQ) provider and the Department is being amended to make permanent a temporary rule adopted May 15, 2013 and adjust the protected eligibility requirements. Under this amendment, protected eligibility is expanded to include self-employed caretakers and caretakers who become students who are continuing to actively seek employment during the hours the OPQ contracted child care program is operating and are available to work during the operating hours of the OPQ provider. This amendment also extends protected eligibility to caretakers whose loss of employment meets good cause criteria. Under this amendment, protected eligibility for the child will not cover child care when the child no longer attends an OPQ provider. This amendment also clarifies that TANF clients do not make a co-payment when TANF covers their child care.

OAR 461-135-0570 about eligible and ineligible students for the Supplemental Nutrition Assistance (SNAP) Program is being amended to make permanent a temporary rule amendment adopted May 1, 2013 modifying and clarifying the eligibility requirements to reduce staff workload and errors in applying the policy. Under the revised student eligibility criteria, students are not eligible on the basis that no work study positions are available. This amendment also clarifies student ineligibility when the student withdraws from classes or reduces credit hours to less than half time.

OAR 461-135-0920 about refugees applying for SSI is being amended to limit references to the Refugee Medical program, which is not a cash program, remove references to OSIP because the OSIP payment ended in 2010, and remove reference to the interim assistance agreement for SSI applicants, which no longer exists. Under the amendment, Refugee program benefits will simply end when SSI begins.

OAR 461-135-0930 about medical coverage for refugees in the Refugee Medical program is being amended to broaden the list of medical programs REFM must mirror in terms of medical benefits.

This rule is also being amended to include policies previously in OAR 461-135-0010 under which some clients may continue receive medical coverage through REFM, even though they may lose medical coverage from other Oregon medical programs or due to moving from another state; and that once a client is determined eligible, the client will maintain that eligibility until the end of the first eight months in the U.S. even if the client becomes ineligible for REF due to income.

OAR 461-150-0060 about prospective or retrospective eligibility and budgeting is being amended to clarify how the eligibility and budgeting policy applies to the Refugee Medical program.

OAR 461-160-0010 about the use of resources in determining financial eligibility is being amended to make permanent temporary rule changes made on April 10, 2013 that removed the Refugee Medical (REFM) program from the programs listed countable resource limits. This rule is also being amended to remove the resource limit as an eligibility requirement for the MAA, MAF, SAC, and OHP-OPU medical programs as part of early implementation of federal changes that expand medical eligibility.

OAR 461-170-0011 about changes that must reported is being amended as part of early implementation of federal changes in medical eligibility that eliminate the resource limit as an eligibility requirement for the MAA, MAF, and SAC programs. This rule is also being amended to revise what needs to be reported in the REF, SFPSS, and TANF programs.

OAR 461-190-0211 about case plan activities and standards for support service payments for the Department's Temporary Assistance for Needy Families Job Opportunity and Basic Skills (JOBS) program is being amended to make permanent a temporary rule change adopted July 1, 2013, modifying program restrictions implemented July 1, 2011 as a result of budget reductions from the 2011 legislative session. This amendment promotes local JOBS service delivery in a way that better responds to local service and client needs. The changes expand the JOBS contracted services array to add crisis intervention family stability activities. High School and GED services are no longer limited only to teen parents. Support services payments will be allowed for life skills, on-the-job training, adult basic education, and SSI application process. Support services child care will be available for two-parent families.

OAR 461-195-0501 about definitions and categories of overpayments is being amended to make permanent temporary rule changes effective March 25, 2013 that remove its definition of trafficking (trading) for the SNAP program in conjunction with other rule changes that expand this definition based on federal law changes, and relocate the definition (to OAR 461-195-0601) to make it easier to locate.

OAR 461-195-0541 about liability for overpayments is being amended to make permanent the temporary rule amendment of March 25, 2013 that clarified the policy for SNAP overpayment liability due to SNAP benefit trafficking, consistent with federal law. This amendment also supports implementation of additional federal SNAP trafficking definitions. Under this amendment, there is overpayment liability for the buying, selling, stealing or other exchange of SNAP benefits for cash or consideration other than eligible food; the exchange of firearms, ammunition, explosives or controlled substances for SNAP benefits; purchasing a product with SNAP benefits that has a container return deposit with the intent of obtaining cash by intentionally discarding the product and returning the container for the deposit return; purchasing a product with SNAP benefits with the intent of obtaining cash or consideration other than eligible food by intentionally reselling the product purchased with SNAP benefits; and intentionally purchasing products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food.

OAR 461-195-0601 about Intentional Program Violation definitions is being amended to make permanent the temporary rule amendment of March 25, 2013, incorporating the expanded federal SNAP trafficking definitions that went into effect March 25, 2013. The current SNAP trafficking definition is moved from OAR 461-195-0501 to OAR 461-195-0601 to support intent of federal regulations by making the definition easier to locate. The amended SNAP trafficking definition now includes: the buying, selling, stealing or other exchange of SNAP benefits for cash or consideration other than eligible food either directly or indirectly, in complicity or collusion with others or acting alone; the exchange of firearms, ammunition, explosives, or controlled substances for SNAP benefits; the intentional disposing of product from containers with the intent to exchange the container solely for the cash refund; Intentionally reselling or exchanging food purchased with SNAP benefits for cash or other non-SNAP eligible items; and Intentionally purchasing products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food.

OAR 461-195-0621 about Intentional Program Violation penalties and liability for overpayments is being amended to make permanent the March 25, 2013 temporary rule amendment implementing changes in federal law for the Supplemental Nutrition Assistance Program (SNAP), under which disqualifications from the Food Distribution Program on Indian Reservations (FDPIR) to continue in effect in Oregon. This rule is also being amended to clarify when an Intentional Program Violation is established against a person in the SNAP and TANF programs. This amendment also implements the expanded federal definition of SNAP trafficking in the context of what triggers a permanent disqualification.

In addition, the above rules may also be changed to reflect new Department terminology and to correct formatting and punctuation.

Written comments may be submitted until August 23, 2013 at 5:00 p.m. Written comments may be e-mailed to Annette.Tesch@state.or.us, faxed to 503-373-7032, or mailed to Annette Tesch, Rules Coordinator, DHS — Self-Sufficiency Programs, 500 Summer Street NE, E-48, Salem, Oregon, 97301. The Department provides the same consideration to written comment as it does to any oral or written testimony provided at the public hearing.

Rules Coordinator: Annette Tesch
Address: Department of Human Services, Self-Sufficiency Programs, 500 Summer St. NE, E-48, Salem, OR 97301
Telephone: (503) 945-6067

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Rule Caption: Changing OARs affecting public assistance, medical assistance, or Supplemental Nutrition Assistance Program clients

Date:	**Time:**	**Location:**
8-21-13	10:30 a.m.	500 Summer St. NE, Rm. 254 Salem, OR

Hearing Officer: Annette Tesch
Stat. Auth.: ORS 411.060, 411.070 & 411.706
Other Auth.: 42 USC Sec. 1396r-5(d)(3)
Stats. Implemented: ORS 411.060, 411.070 & 411.706
Proposed Amendments: 461-160-0620
Proposed Repeals: 461-160-0620(T)
Last Date for Comment: 8-23-13, 5 p.m.
Summary: OAR 461-160-0620, relating to the liability calculation for clients in the Oregon Supplemental Income Program Medical (OSIPM, assistance to seniors and people with disabilities) receiving long-term care services, is being amended to make permanent changes adopted by temporary rule on July 1, 2013. These changes reflect the annual federal increase to the minimum maintenance need standard and shelter standard that are used to calculate how much of the client's income can be diverted to the community spouse. This rule is also being amended due to changes in Medicaid funding for community-based care. Some community-based care that was previously funded through Medicaid waivers will now be funded under the State Medicaid Plan. This amendment removes references to waivered care, and as appropriate, replaces the references with references to home and community-based care. Removing references to waivered care will allow the Department to provide community-

based care services under Medicaid waivers or under the Medicaid State Plan, as appropriate, to reflect the change in funding.

In addition, the above rules may also be changed to reflect new Department terminology and to correct formatting and punctuation.

Written comments may be submitted until August 23, 2013 at 5:00 p.m. Written comments may be e-mailed to Annette.Tesch@state.or.us, faxed to 503-373-7032, or mailed to Annette Tesch, Rules Coordinator, DHS — Self-Sufficiency Programs, 500 Summer Street NE, E-48, Salem, Oregon, 97301. The Department provides the same consideration to written comment as it does to any oral or written testimony provided at the public hearing.

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Telephone: (503) 945-6067

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Rule Caption: Changing OARs affecting public assistance, medical assistance, or Supplemental Nutrition Assistance Program clients

Date:	Time:	Location:
8-21-13	10:30 a.m.	500 Summer St. NE, Rm. 254 Salem, OR

Hearing Officer: Annette Tesch
Stat. Auth.: ORS 93.268, 409.050, 410.070, 410.075, 411.060, 411.070, 411.095, 411.101, 411.404, 411.408, 411.660, 411.700, 411.704, 411.706, 411.816, 411.892, 412.014, 412.049, 412.124, 414.042, 414.231, 416.340, 416.350
Stats. Implemented: ORS 93.268, 409.010, 410.070, 410.075, 411.010, 411.060, 411.070, 411.083, 411.095, 411.099, 411.101, 411.103, 411.111, 411.117, 411.404, 411.408, 411.620, 411.630, 411.635, 411.640, 411.660, 411.690, 411.694, 411.700, 411.704, 411.706, 411.708, 411.795, 411.816, 411.892, 412.001, 412.009, 412.014, 412.049, 412.069, 412.124, 414.025, 414.042, 414.231, 414.826, 414.831, 414.839, 416.310, 416.340, 416.350, 2011 OL Ch. 212 Sec. 2 & 2011 OL Ch. 720 Sec. 224
Proposed Amendments: 461-001-0030, 461-025-0310, 461-025-0315, 461-110-0210, 461-135-0726, 461-135-0750, 461-135-0832, 461-135-0835, 461-140-0296, 461-145-0540, 461-145-0580, 461-155-0020, 461-155-0270, 461-155-0530, 461-155-0575, 461-155-0580, 461-155-0630, 461-155-0640, 461-155-0660, 461-160-0055, 461-160-0540, 461-160-0550, 461-160-0551, 461-160-0610, 461-165-0100, 461-175-0230, 461-180-0044, 461-185-0050, 461-195-0521
Proposed Repeals: 461-001-0030(T), 461-025-0310(T), 461-025-0315(T), 461-110-0210(T), 461-135-0726(T), 461-135-0750(T), 461-135-0832(T), 461-135-0835(T), 461-140-0296(T), 461-145-0540(T), 461-145-0580(T), 461-155-0020(T), 461-155-0270(T), 461-155-0530(T), 461-155-0575(T), 461-155-0580(T), 461-155-0630(T), 461-155-0640(T), 461-155-0660(T), 461-160-0055(T), 461-160-0540(T), 461-160-0550(T), 461-160-0551(T), 461-160-0610(T), 461-165-0100(T), 461-175-0230(T), 461-180-0044(T), 461-185-0050(T), 461-195-0521(T)
Last Date for Comment: 8-23-13, 5 p.m.
Summary: OAR 461-001-0030, 461-025-0310, 461-025-0315, 461-110-0210, 461-135-0726, 461-135-0750, 461-135-0832, 461-135-0835, 461-140-0296, 461-145-0540, 461-145-0580, 461-155-0020, 461-155-0270, 461-155-0530, 461-155-0575, 461-155-0580, 461-155-0630, 461-155-0640, 461-155-0660, 461-160-0055, 461-160-0540, 461-160-0550, 461-160-0551, 461-160-0610, 461-165-0100, 461-175-0230, 461-180-0044, 461-185-0050, and 461-195-0521 are being amended to make permanent temporary rule changes effective July 1, 2013 as a result of a change in Medicaid funding for community-based care. Some community-based care that was previously funded through Medicaid waivers will now be funded under the State Medicaid Plan. These amendments remove references to waivered care as appropriate, and as appropriate, replace the references with references to home and community-based care. Other clarifying changes are also being made. Removing references to waivered care will allow the Department to provide community-based care services under Medicaid waivers or under the Medicaid State Plan, as appropriate, to reflect the change in funding. OAR 461-155-0575 about in-home supplementation in the Oregon Supplemental Income Program Medical (OSIPM) is also being amended to reduce the in-home monthly supplemental payment authorized from $30 to $15. OAR 461-165-0100 is also being amended to remove obsolete references concerning medical cards and special needs cases.

In addition, the above rules may also be changed to reflect new Department terminology and to correct formatting and punctuation.

Written comments may be submitted until August 23, 2013, at 5:00 p.m. Written comments may be e-mailed to Annette.Tesch@state.or.us, faxed to 503-373-7032, or mailed to Annette Tesch, Rules Coordinator, DHS — Self-Sufficiency Programs, 500 Summer Street NE, E-48, Salem, Oregon, 97301. The Department provides the same consideration to written comment as it does to any oral or written testimony provided at the public hearing.

Rules Coordinator: Annette Tesch
Address: Department of Human Services, Self-Sufficiency Programs, 500 Summer St. NE, E-48, Salem, OR 97301
Telephone: (503) 945-6067

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Rule Caption: Changing OARs affecting public assistance, medical assistance, or Supplemental Nutrition Assistance Program clients

Date:	Time:	Location:
8-21-13	9:30 a.m.	500 Summer St. NE, Rm. 257 Salem, OR

Hearing Officer: Annette Tesch
Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.400, 411.404, 411.706, 411.816, 412.014, 412.049 & 414.231
Stats. Implemented: ORS 409.050, 411.060, 411.070, 411.117, 411.400, 411.404, 411.816 & 412.049
Proposed Amendments: 461-110-0340, 461-125-0010, 461-125-0030, 461-125-0050, 461-125-0060, 461-125-0090, 461-125-0110, 461-125-0120, 461-125-0130, 461-125-0170, 461-125-0230, 461-125-0250, 461-135-1100, 461-135-1101, 461-140-0210, 461-140-0300, 461-160-0015
Proposed Repeals: 461-135-1100(T), 461-135-1101(T)
Last Date for Comment: 8-23-13, 5 p.m.
Summary: OAR 461-110-0340, 461-125-0010, 461-125-0030, 461-125-0050, 461-125-0060, 461-125-0090, 461-125-0110, 461-125-0120, 461-125-0130, 461-125-0170, 461-125-0230, and 461-125-0250 are being amended to revise medical eligibility policies so that deprivation will no longer be an eligibility requirement for the MAA (Medical Assistance Assumed) and MAF (Medical Assistance to Families) programs. These rules are also being amended to add and clarify cross references to defined terms for the TANF program.

OAR 461-135-1100 about Oregon Health Plan (OHP) eligibility requirements and OAR 461-135-1101 about Healthy KidsConnect (HKC) eligibility requirements are being amended to make permanent temporary rule changes adopted July 1, 2013 that identify the standards by which private major medical health insurance (or Third Party Liability — TPL) may be considered inaccessible and thus does not preclude eligibility for OHP-OPU, OHP-CHP, and Healthy KidsConnect (HKC) programs. OAR 461-135-1100 is also being amended to remove the resource limit as an eligibility requirement for the OHP-OPU medical program as part of early implementation of federal changes that expand medical eligibility.

OAR 461-140-0210, 461-140-0300, and 461-160-0015 are being amended to remove the resource limit as an eligibility requirement for the MAA, MAF, SAC, and OHP-OPU medical programs as part of early implementation of federal changes that expand medical eligibility.

In addition, the above rules may also be changed to reflect new Department terminology and to correct formatting and punctuation.

Written comments may be submitted until August 23, 2013 at 5:00 p.m. Written comments may be e-mailed to Annette.Tesch@

state.or.us, faxed to 503-373-7032, or mailed to Annette Tesch, Rules Coordinator, DHS — Self-Sufficiency Programs, 500 Summer Street NE, E-48, Salem, Oregon, 97301. The Department provides the same consideration to written comment as it does to any oral or written testimony provided at the public hearing.
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Telephone: (503) 945-6067

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Department of Transportation,
Driver and Motor Vehicle Services Division
Chapter 735

Rule Caption: Bulk Records for Crash Reports and Implied Consent Reports No Longer Available
Stat. Auth.: ORS 184.616, 184.619, 802.010, 802.179, 802.183, 802.200, 802.220 & 802.230
Stats. Implemented: ORS 746.265, 802.179, 802.200, 802.220, 802.230 & 825.412
Proposed Amendments: 735-010-0030
Last Date for Comment: 8-21-13, Close of Business
Summary: The Driver and Motor Vehicle Services Division of the Oregon Department of Transportation (DMV) is discontinuing the bulk sale of Implied Consent Combined Reports and Oregon Police Traffic Crash Reports. This action is being taken as a result of the U.S. Supreme Court decision in Maracich v. Spears, 570 U.S. ___, 133 S. Ct. 2191 (2013). The Supreme Court ruling states that solicitation of clients is not a use of personal information that is authorized by the "investigation in anticipation of litigation" exception to the Federal Driver Privacy Protection Act (DPPA) prohibition on use of personal information from motor vehicle records. Oregon statutes that implement this DPPA exception use the same language that was interpreted by the Supreme Court. Based on this ruling, DMV is no longer providing bulk sales of Implied Consent Combined Reports and Oregon Police Traffic Crash Reports under the exception in ORS 802.177(4)(a).

The only reference in administrative rule that DMV has regarding these bulk sales is in OAR 735-010-0030(6). DMV proposes to amend OAR 735-010-0030(6) to remove that reference. DMV is also deleting section (12)(b) of this rule because driver record lists are no longer provided on paper or magnetic tape.

Text of proposed and recently adopted ODOT rules can be found at web site http://www.oregon.gov/ODOT/CS/RULES/.
Rules Coordinator: Lauri Kunze
Address: Department of Transportation, Driver and Motor Vehicle Services Division, 355 Capitol St. NE, MS 51, Salem, OR 97301
Telephone: (503) 986-3171

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Rule Caption: Mandatory Reporting Requirements of Medically At-Risk Drivers and ID Card Availability When Voluntarily Quits Driving
Stat. Auth.: ORS 184.616, 184.619, 802.010, 807.040, 807.050, 807.400, 807.710 & 809.419
Stats. Implemented: ORS 802.010(1)(c), 807.021, 807.022, 807.400, 807.710 & 809.419
Proposed Amendments: 735-062-0010, 735-062-0135, 735-074-0080, 735-074-0090
Last Date for Comment: 8-21-13, Close of Business
Summary: Oregon Laws 2011, Chapter 295, section 1 (HB 3185), created a work group in the Department of Transportation to evaluate the department's At-Risk Driver Program and consider different assessment tools and options for enhancing the program. This work group included experts in geriatrics, general medicine, driving assessment, research practices, and law enforcement, as well as an advocate for senior citizens.

In assessing the current At-Risk Driver Program the work group made recommendations to amend the current rules as follows:

* Modify the definition of "uncontrollable" to include the term "persistent."

* Expand mandatory reporting to include medical professionals who provide specialist evaluations or health care services that result from a referral by another physician or health care provider.

* Specify that reporting is not required if a patient is incapacitated and not expected to regain the ability to drive.

The proposed amendments of OAR 735-074-0080 and 735-074-0090 make the changes recommended by the work group.

The work group also recommended that DMV rules and forms related to surrender of driving privileges be amended. ORS 807.400 authorizes DMV to issue a no fee identification card if a person acknowledges he or she is no longer competent to drive. The work group determined that this language has a negative connotation for persons retiring their driving privileges, and recommended that DMV rules and forms use the words "no longer able to drive safely" which is consistent with ORS 807.060. DMV proposes to amend OAR 735-062-0010(7)(a) and 735-062-0135(4) to replace the words "no longer competent to drive" with the words "no longer able to drive safely."

Text of proposed and recently adopted ODOT rules can be found at web site http://www.oregon.gov/ODOT/CS/RULES/.
Rules Coordinator: Lauri Kunze
Address: Department of Transportation, Driver and Motor Vehicle Services Division, 355 Capitol St. NE, MS 51, Salem, OR 97301
Telephone: (503) 986-3171

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Rule Caption: Waiver of Drive Test When Applicant Has Completed an Approved Driver Education Program
Stat. Auth.: ORS 184.616, 184.619, 802.010, 807.070, 807.072, 807.080, 807.170 & 807.175
Stats. Implemented: ORS 807.070, 807.072, 807.080, 807.170 & 807.175
Proposed Amendments: 735-062-0080, 735-062-0140
Last Date for Comment: 8-21-13, Close of Business
Summary: The Oregon Department of Transportation, Transportation Safety Division (TSD), oversees driver education in Oregon. TSD has built a very robust driver education program, where the instructors must complete many hours of specialized training and the curriculum used by all providers is consistent and uses best practices to successfully teach safe driving behaviors. All TSD-approved driver education programs require students to pass a drive test to successfully complete the course. TSD is working to standardize the drive test procedures used by all providers. During this standardization process, DMV will coordinate with TSD to make certain that the drive test meets or exceeds the requirements of a Class C drive test conducted by DMV.

ORS 807.072 (1)(a) authorizes DMV, by administrative rule, to waive any test establishing qualification for a driver license where the person can provide satisfactory proof that they have passed an equivalent test that is given in conjunction with a traffic safety education course certified by the Department under ORS 802.345. DMV proposes to amend OAR 735-062-0080 to state that DMV will waive the drive test portion of DMV testing for any person who provides a Driver Education Certificate of Completion card issued by a TSD-approved traffic safety education course provider, if the drive test that the person passed to successfully complete the course meets or exceeds DMV's Class C drive test. DMV also proposes to amend OAR 735-062-0140 to establish the specific proof of completion of a traffic safety education course that DMV will accept.

Text of proposed and recently adopted ODOT rules can be found at web site http://www.oregon.gov/ODOT/CS/RULES/.
Rules Coordinator: Lauri Kunze
Address: Department of Transportation, Driver and Motor Vehicle Services Division, 355 Capitol St. NE, MS 51, Salem, OR 97301
Telephone: (503) 986-3171

Rule Caption: Witness Information, Requests for Admissions, and Written Interrogatories in Implied Consent Hearings
Stat. Auth.: ORS 183.341, 184.616, 184.619, 802.010, 813.410 & 813.440
Other Auth.: OAR 137-003-0566(2)
Stats. Implemented: ORS 813.410 & 813.440
Proposed Adoptions: 735-090-0066
Last Date for Comment: 8-21-13, Close of Business
Summary: Most contested case hearings for implied consent cases are conducted under extremely tight timelines in accordance with ORS 813.410, with the hearing held and the final order issued within 30 days of arrest. This tight timeframe leaves little to no extra time for DMV and the Office of Administrative Hearings (OAH) to engage in the discovery methods described under OAR 137-003-0566. There are limited exceptions to the statutory timelines set forth in ORS 813.440, which do not include requests for discovery. Approximately 250 implied consent hearings are conducted each month. The relevant documents are provided to the petitioner as discovery prior to the hearing, namely the police report described in ORS 813.120, which includes the name and telephone number of the reporting officer who will testify at hearing, and other documents DMV intends to offer as exhibits. Recently, the Department of Justice adopted new model rules for discovery methods in contested cases. Under OAR 137-003-0566(2) an agency may determine that certain forms of discovery are not allowed in a category of cases when the agency meets certain conditions. DMV finds that the discovery methods listed in OAR 137-003-0566(1)(a), (d), and (e) (the names, telephone numbers, and addresses of witnesses expected to testify at the hearing, requests for admissions, and written interrogatories respectively) would unduly complicate and interfere with the hearing processes in implied consent cases due to the volume of cases and need for speed and informality in these cases. The current alternative procedures for sharing relevant information, including those established in Oregon Administrative Rule, Chapter 735, Division 90, are sufficient to ensure fundamental fairness in implied consent contested case hearings. In addition, the names of the possible witnesses that will testify on the agency's behalf are already included in the documents DMV provides to a petitioner prior to hearing. Therefore DMV proposes to adopt OAR 735-090-0066 to establish that witness information, requests for admissions, and written interrogatories do not apply to and may not be used as discovery methods in implied consent contested case hearings.

Text of proposed and recently adopted ODOT rules can be found at web site http://www.oregon.gov/ODOT/CS/RULES/.
Rules Coordinator: Lauri Kunze
Address: Department of Transportation, Driver and Motor Vehicle Services Division, 355 Capitol St. NE, MS 51, Salem, OR 97301
Telephone: (503) 986-3171

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Rule Caption: Commercial Drive School Certificate and Instructor Certificate Requirements
Stat. Auth.: ORS 184.616, 184.619, 802.010, 822.505, 822.510, 822.515, 822.525 & 822.530
Stats. Implemented: ORS 822.500, 822.510, 822.515, 822.525 & 822.530
Proposed Amendments: 735-160-0003, 735-160-0005, 735-160-0010, 735-160-0011, 735-160-0015, 735-160-0020, 735-160-0035, 735-160-0075, 735-160-0080, 735-160-0095, 735-160-0100, 735-160-0115, 735-160-0125, 735-160-0130
Last Date for Comment: 8-21-13, Close of Business
Summary: The rules in OAR Chapter 735, Division 160 outline the requirements for a Commercial Driver Training School Certificate and a Driver Training Instructor Certificate. DMV issues these certificates and also performs on-site audits of the drive school, their records and instruction. In performing these function and reviewing these rules, DMV determined that a few minor changes should be made to improve both the rules and the program. Many changes are simply for clarity and consistency. Substantive changes include the following:

* Exempting a business from obtaining a Commercial Driver Training School Certificate if it only provides off-road instruction in vehicles with equipment which simulate hazardous driving conditions to persons holding valid driver licenses.

* Updating offenses that disqualify an applicant as an Operator or Instructor to include involuntary servitude and trafficking in persons.

* Requiring a person who conducts behind-the-wheel training to have had a driver license for a minimum of five years;

* Requiring an applicant for an instructor certificate to disclose prior certification(s) in another state on the application;

* Requiring an applicant for an instructor certificate to provide an explanation or evidence if he or she self-reports a medical condition or the person is in the DMV medically at-risk program. DMV will review information provided by the applicant and determine if the person qualifies to be an Instructor, notwithstanding the medical or physical condition.

* Modifying the sanctions to make them more consistent and appropriate for the violation.

Text of proposed and recently adopted ODOT rules can be found at web site http://www.oregon.gov/ODOT/CS/RULES/.
Rules Coordinator: Lauri Kunze
Address: Department of Transportation, Driver and Motor Vehicle Services Division, 355 Capitol St. NE, MS 51, Salem, OR 97301
Telephone: (503) 986-3171

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Department of Transportation,
Highway Division
Chapter 734

Rule Caption: Map-21 Special Permit During Periods of National Emergency
Stat. Auth.: ORS 184.616, 184.619 & 823.011
Other Auth.: 42 U.S.C. 5121 et seq. & 23 U.S.C. 127 — Sec. 127; Vehicle weight limitations - Interstate System
Stats. Implemented: ORS 818.200, 818.210, 818.220 & 818.225
Proposed Adoptions: 734-082-0085
Last Date for Comment: 8-21-13, Close of Business
Summary: MAP-21, the Moving Ahead for Progress in the 21st Century Act (P.L. 112-141), was signed into law by President Obama on July 6, 2012. Funding surface transportation programs at over $105 billion for fiscal years (FY) 2013 and 2014, MAP-21 is the first long-term highway authorization enacted since 2005.

Section 127 of title 23, U.S.C., establishes weight limitations for vehicles operating on the Interstate System. Section 127 states that the overall gross weight may not exceed 80,000 lbs., including all enforcement tolerances, except for those vehicles and loads which cannot be easily dismantled or divided and which have been issued Special Permits in accordance with applicable State laws. This language establishes the States' authority to issue Special Permits to "non-divisible" loads. Examples of non-divisible loads include: bulldozers, large generators, scrapers, and modular homes.

Section 1511 of MAP-21 extends the States' authority to issue Special Permits to vehicles with divisible loads that are delivering relief supplies during a Presidentially-declared emergency or major disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act ("Stafford Act") (42 U.S.C. 5121 et seq.). The proposed rule adoption is necessary to ensure Oregon is in compliance with the federal regulations.

Text of proposed and recently adopted ODOT rules can be found at web site http://www.oregon.gov/ODOT/CS/RULES/.
Rules Coordinator: Lauri Kunze
Address: Department of Transportation, Highway Division, 355 Capitol St. NE, MS 51, Salem, OR 97301
Telephone: (503) 986-3171

Higher Education Coordinating Commission
Chapter 715

Rule Caption: Rules delegating duties, and powers of the Higher Education Coordinating Commission relative to degree authorization

Date:	Time:	Location:
8-19-13	2 p.m.	775 Court St. NE Salem, OR 97301

Hearing Officer: Seth Allen
Stat. Auth.: Enrolled SB 242
Stats. Implemented:
Proposed Adoptions: 715-010-0000, 715-010-0015, 715-010-0025
Last Date for Comment: 8-19-13, Close of Business
Summary: Temporary rules (715-010-0005, 715-010-0010 and 715-010-0020) were passed by the Higher Education Coordinating Commission and have expired. These rules regard the delegation of duties, functions, and powers of the Higher Education Coordinating Commission relative to the Office of Degree Authorization. The Office needs to provide the functions described in temporary rules and the Higher Education Coordinating Commission is seeking to make the rules permanent.
Rules Coordinator: Seth Allen
Address: Higher Education Coordinating Commission, 155 Cottage St. NE, Salem, OR 97310
Telephone: (503) 378-8213

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Land Conservation and Development Department
Chapter 660

Rule Caption: Electronic submittal of proposed and adopted changes to comprehensive land use plans.

Date:	Time:	Location:
9-26-13	8 a.m.	635 Capitol St. NE Basement Hearing Rm. Salem, OR 97301

Hearing Officer: LCDC
Stat. Auth.: ORS 197.040
Stats. Implemented: ORS 197.610–197.625
Proposed Amendments: Rules in 660-018
Last Date for Comment: 9-26-13, Close of Hearing
Summary: These rules implement the statutes that direct local government notification to the Department of Land Conservation and Development of proposed and adopted changes to comprehensive land use plans and land use regulations. The rules currently require hard-copy notification (that is, that notices be provided on paper); the proposed rule amendments will allow local governments to submit these notices electronically, such as via e-mail, without providing paper copies.
Rules Coordinator: Casaria Taylor
Address: Land Conservation and Development Department, 635 Capitol St. NE, Suite 150, Salem, OR 97301
Telephone: (503) 373-0050, ext. 322

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Oregon Business Development Department
Chapter 123

Rule Caption: These rules relate to the programs within the Office Minority Women and Emerging Small Business.
Stat. Auth.: ORS 200.055
Stats. Implemented: ORS 200.055, 200.170 & 279.011
Proposed Adoptions: 123-200-1400, 123-200-1500, 123-200-1600, 123-200-1700, 123-200-1800, 123-200-1900
Proposed Amendments: 123-200
Proposed Repeals: 123-200-0030, 123-200-0050, 123-200-0060, 123-200-0070, 123-200-0080, 123-200-0100, 123-200-0120, 123-200-0130, 123-200-0140, 123-200-0150, 123-200-0160, 123-200-0170, 123-200-0200
Proposed Ren. & Amends: 123-200-0005 to 123-200-1000, 123-200-0010 to 123-200-1100, 123-200-0020 to 123-200-1200, 123-200-0040 to 123-200-1300, 123-200-0090 to 123-200-2000, 123-200-0180 to 123-200-2100, 123-200-0190 to 123-200-2200
Last Date for Comment: 8-23-13, Close of Business
Summary: The certification procedures for Minority Business Enterprises, Women Business Enterprises and Emerging Small Business have been separated into their prospective procedures. Definitions have been amended. The entire division has been renumbered beginning at 123-200-1000.
Rules Coordinator: Mindee Sublette
Address: Oregon Business Development Department, 775 Summer St. NE, Suite 200, Salem, OR 97301
Telephone: (503) 986-0036

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Oregon Facilities Authority
Chapter 172

Rule Caption: Amendment of OAR 172-005-0020(3) addressing the Consideration of Application by the Authority

Date:	Time:	Location:
9-10-13	2 p.m.	888 SW Fifth Ave., Suite 1600 Portland, OR

Hearing Officer: Gwendolyn Griffith
Stat. Auth.: ORS 289.125(1) & 289.240(2)
Stats. Implemented: ORS 289.005, 289.010, 289.125, 289.200, 289.240(2)
Proposed Amendments: 172-005-0020
Last Date for Comment: 9-9-13, 5 p.m.
Summary: Oregon Facilities Authority (Authority) is amending OAR 172-005-0020(3), Consideration of Application by the Authority. The amendment to OAR 172-005-0020(3) clarifies the approval process by the Authority. It changes the approval process so that the approval resolution is in the form recommended, not provided, by the Authority's bond counsel. Additionally, it adds that the recommended resolution may include additional or different provisions as the Authority deems necessary or appropriate. Lastly, the approval resolution which requires execution and delivery by the participating institution of a preliminary agreement regarding the requested financing substantially in the form which is attached to the resolution as an exhibit may include such additional or different provisions as the Authority deems necessary or appropriate.
Rules Coordinator: Gwendolyn Griffith
Address: Oregon Facilities Authority, 888 SW 5th Ave., Suite 1600, Portland, OR 97204
Telephone: (503) 802-5710

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Rule Caption: Adoption of OAR 172-005-0045 addressing Post-Issuance Compliance.

Date:	Time:	Location:
9-10-13	2 p.m.	888 SW Fifth Ave., Suite 1600 Portland, OR 97204

Hearing Officer: Gwendolyn Griffith
Stat. Auth.: ORS 289.125(1) & 289.240(2)
Stats. Implemented: ORS 289.005, 289.010, 289.125, 289.200 & 289.240(2)
Proposed Adoptions: 172-005-0045
Last Date for Comment: 9-9-13, 5 p.m.
Summary: Oregon Facilities Authority is proposing to adopt OAR 172-005-0045, under Division 5, Evaluating and Approving Projects Which Qualify for Tax-exempt Financing. OAR 172-005-0045 addresses post-issuance compliance procedures with participating institutions to ensure compliance with federal tax, federal and state securities, and other applicable laws and regulations. OAR 172-005-0045 establishes that participating institutions are required to provide the following at the time of issuance of bonds: 1) a copy of post-issuance compliance procedures duly adopted that establish appropriate internal procedures to ensure compliance, 2) a copy of any modification or amendment of such procedures, and 3) a copy of evidence of due adoption and approval of such procedures. OAR 172-

005-0045 also requires participating institutions to designate the person(s) with primary responsibility for compliance.
Rules Coordinator: Gwendolyn Griffith
Address: Oregon Facilities Authority, 888 SW 5th Ave., Suite 1600, Portland, OR 97204
Telephone: (503) 802-5710

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Oregon Health Authority,
Division of Medical Assistance Programs
Chapter 410

Rule Caption: Revise Health Care-Acquired Conditions policy to include Critical Access Hospitals

Date:	Time:	Location:
8-16-13	10:30 a.m.	500 Summer St. NE, Rm. 137C Salem, OR 97301

Hearing Officer: Cheryl Peters, dmap.rules@state.or.us
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Proposed Amendments: 410-125-0450
Last Date for Comment: 8-19-13, 5 p.m.
Summary: OAR 410-125-0450 revises the Health Care-Acquired Conditions policy to include Critical Access Hospitals for reporting the present on admission indicator on inpatient hospital claims.
Rules Coordinator: Cheryl Peters
Address: Oregon Health Authority, Division of Medical Assistance Programs, 500 Summer St. NE, Salem, OR 97301
Telephone: (503) 945-6527

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Rule Caption: Add Coordinated Care Organization language (CCO) for dental integration

Date:	Time:	Location:
8-16-13	10:30 a.m.	500 Summer St. NE, Room 137C Salem, OR 97301

Hearing Officer: Cheryl Peters, dmap.rules@state.or.us
Stat. Auth.: ORS 413.042, 414.065, 414.071, 414.651 & 414.707
Stats. Implemented: ORS 414.065, 414.651 & 414.707
Proposed Amendments: 410-123-1160, 410-123-1260, 410-123-1490, 410-123-1600
Last Date for Comment: 8-19-13, 5 p.m.
Summary: The Division needs to permanently amend these rules to incorporate necessary language related to dental services under the responsibility of Coordinated Care Organizations (CCO). Minor changes have been made for clarity of rule language.
Rules Coordinator: Cheryl Peters
Address: Oregon Health Authority, Division of Medical Assistance Programs, 500 Summer St. NE, Salem, OR 97301
Telephone: (503) 945-6527

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Rule Caption: Add Dental Care Organization language (DCO) language for dental integration into CCO's

Date:	Time:	Location:
8-16-13	10:30 a.m.	500 Summer St. NE, Rm. 137C Salem, OR 97301

Hearing Officer: Cheryl Peters, dmap.rules@state.or.us
Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610–414.685
Proposed Amendments: 410-141-3060, 410-141-3080, 410-141-3220, 410-141-3420
Last Date for Comment: 8-19-13, 5 p.m.
Summary: The Division needs to amend these rules to incorporate language related to dental services being integrated into the Coordinated Care Organizations (CCO). Changes have been made for clarity of rule language; the addition of effective dates, behavioral health and Dental Care Organization.
Rules Coordinator: Cheryl Peters
Address: Oregon Health Authority, Division of Medical Assistance Programs, 500 Summer St. NE, Salem, OR 97301
Telephone: (503) 945-6527

Rule Caption: The Authority proposes to amend rules to be consistent with 42 CFR 438.408

Date:	Time:	Location:
8-16-13	10:30 a.m.	500 Summer St. NE, Rm. 137C Salem, OR 97301

Hearing Officer: Cheryl Peters, dmap.rules@state.or.us
Stat. Auth.: ORS 413.042 & 414-065
Stats. Implemented: ORS 414.065
Proposed Amendments: 410-141-0262, 410-141-3262
Last Date for Comment: 8-19-13, 5 p.m.
Summary: Division 141, Oregon Health Plan rules govern policies and requirements for the Coordinated Care Organizations (CCO) under Oregon's Integrated and Coordinated Health Care Delivery System. The Authority proposes to amend rules to be consistent with 42 CFR 438.408.
Rules Coordinator: Cheryl Peters
Address: Oregon Health Authority, Division of Medical Assistance Programs, 500 Summer St. NE, Salem, OR 97301
Telephone: (503) 945-6527

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Rule Caption: Align with Department of Human Services OAR chapter 461, medical eligibility rules

Date:	Time:	Location:
8-16-13	10 a.m.	500 Summer St. NE, Rm. 137C Salem, OR 97301,

Hearing Officer: Cheryl Peters, dmap.rules@state.or.us
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042 & 414.065
Proposed Amendments: 410-120-0006
Last Date for Comment: 8-19-13, 5 p.m.
Summary: The General Rules Program administrative rules govern the Division's payments for services provided to clients and medical assistance eligibility determinations made by the Oregon Health Authority. In coordination with the Department of Human Services' (Department) revision of medical eligibility rules in chapter 461, the Division is amending OAR 410-120-0006 to assure that the Division's medical eligibility rule aligns with and reflects information found in the Department's medical eligibility rules. In OAR 410-120-0006, the Division adopts in rule by reference Department eligibility rules and must update OAR 410-120-0006 in conjunction.
Rules Coordinator: Cheryl Peters
Address: Oregon Health Authority, Division of Medical Assistance Programs, 500 Summer St. NE, Salem, OR 97301
Telephone: (503) 945-6527

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Oregon Health Authority,
Office for Oregon Health Policy and Research
Chapter 409

Rule Caption: Adoption of administrative rules governing the Medicaid Primary Care Provider Loan Repayment Program

Date:	Time:	Location:
8-19-13	2 p.m.	General Services Bldg. Mt. Mazama Rm. 1225 Ferry St. SE Salem, OR 97301

Hearing Officer: Zarie Haverkate
Stat. Auth.: 2013 OL Ch. 177
Stats. Implemented: 2013 OL Ch. 177
Proposed Adoptions: 409-037-0000, 409-037-0010, 409-037-0020, 409-037-0030, 409-037-0040, 409-037-0050, 409-037-0060, 409-037-0070, 409-037-0080
Last Date for Comment: 8-21-13, 5 p.m.
Summary: These rules establish standards for the implementation of the new Medicaid Primary Care Loan Repayment Program as mandated by the 2013 Legislature, Senate Bill 440. The Program provides loan repayment supports to primary care providers who commit to serving Medicaid patients in underserved areas of the State. The Program supports the Affordable Care Act and Oregon's

health system transformation efforts to ensure an adequate supply of primary care providers.
Rules Coordinator: Zarie Haverkate
Address: Oregon Health Authority, Office for Oregon Health Policy and Research, 1225 Ferry St. SE, Salem, OR 97301
Telephone: (503) 373-1574

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Rule Caption: Adoption of Administrative Standards for Health Professional Student Clinical Training

Date:	Time:	Location:
8-19-13	1 p.m.	General Services Bldg. Mt. Mazama Rm. 1225 Ferry St SE Salem, OR 97301

Hearing Officer: Zarie Haverkate
Stat. Auth.: ORS 413.435
Stats. Implemented: ORS 413.435
Proposed Adoptions: 409-030-0100, 409-030-0110, 409-030-0120, 409-030-0130, 409-030-0140, 409-030-0150, 409-030-0160, 409-030-0170, 409-030-0180, 409-030-0190, 409-030-0200, 409-030-0210, 409-030-0220, 409-030-0230, 409-030-0240, 409-030-0250
Last Date for Comment: 8-21-13, 5 p.m.
Summary: These rules establish standards for administrative requirements for health professional student placements in clinical training settings within the state of Oregon. The intended purpose of the standards is to mitigate inconsistencies that currently exist across clinical placements; promote efficient solutions to reduce costs for students, schools, and clinical placement sites; and to ensure patient, clinical staff and student safety. These standards pertain to credentials that applicable students must obtain and requirements that clinical placement sites can set.
Rules Coordinator: Zarie Haverkate
Address: Oregon Health Authority, Office for Oregon Health Policy and Research, 1225 Ferry St. SE, Salem, OR 97301
Telephone: (503) 373-1574

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Oregon Health Authority,
Oregon Educators Benefit Board
Chapter 111

Rule Caption: Removing development of benefit plans from rule and updating new plans and plan requirements

Date:	Time:	Location:
8-19-13	10 a.m.	1225 Ferry St. SE, OEBB Boardroom Salem, OR 97301

Hearing Officer: OEBB Staff
Stat. Auth.: ORS 243.860–243.886
Stats. Implemented: ORS 243.864(1)(a)
Proposed Amendments: 111-030-0010, 111-030-0046
Proposed Repeals: 111-030-0001, 111-030-0005, 111-030-0020, 111-030-0025
Last Date for Comment: 8-31-13, Close of Business
Summary: Removing development of benefit plans from rule, as this language applied to the OEBB benefit program when the program was in development. Benefit plan selection no longer applies since the Board made the decision to no longer restrict plans. Amendments made to plan selection criteria and the Health Savings Account section update new plans and plan requirements.
Rules Coordinator: April Kelly
Address: Oregon Health Authority, Oregon Educators Benefit Board, 1225 Ferry St. SE, Salem, OR 97301
Telephone: (503) 378-6588

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Rule Caption: Amendments update language regarding eligibility verifications and reviews

Date:	Time:	Location:
8-19-13	10: a.m.	1225 Ferry St. SE OEBB Boardroom. Salem, OR 97301

Hearing Officer: OEBB Staff
Stat. Auth.: ORS 243.860 to-243.886
Stats. Implemented: ORS 243.864(1)(a)
Proposed Amendments: 111-040-0015
Last Date for Comment: 8-31-13, Close of Business
Summary: Amendments update language that aligns with the new eligibility verification and review language in OEBB's Division 80, Operations rule.
Rules Coordinator: April Kelly
Address: Oregon Health Authority, Oregon Educators Benefit Board, 1225 Ferry St. SE, Salem, OR 97301
Telephone: (503) 378-6588

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Rule Caption: Amendments update and clarify language related to early retirees

Date:	Time:	Location:
8-19-13	10 a.m.	1225 Ferry St.SE OEBB Boardroom Salem, OR 97301

Hearing Officer: OEBB Staff
Stat. Auth.: ORS 243.860–243.886
Stats. Implemented: ORS 243.864(1)(a)
Proposed Amendments: 111-050-0010, 111-050-0050
Last Date for Comment: 8-31-13, Close of Business
Summary: Amendments to 111-050-0010 align the definition of Eligible Early Retiree with OEBB's definition under Division 10 and clarify the language related continuation of coverage from active coverage to retiree coverage. Amendments to 111-00-0050 update language that aligns with the new eligibility verification and review language in OEBB's Division 80 Operations rule.
Rules Coordinator: April Kelly
Address: Oregon Health Authority, Oregon Educators Benefit Board, 1225 Ferry St. SE, Salem, OR 97301
Telephone: (503) 378-6588

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Rule Caption: Amendments to this rule update plans available, open enrollment period and premium payments

Date:	Time:	Location:
8-19-13	10 a.m.	1225 Ferry St.SE OEBB Boardroom Salem, OR 97301

Hearing Officer: OEBB Staff
Stat. Auth.: ORS 243.860 to-243.886
Stats. Implemented: ORS 243.864(1)(a)
Proposed Amendments: 111-070-0005, 111-070-0015, 111-070-0050
Last Date for Comment: 8-31-13, Close of Business
Summary: Amendments to 111-070-0005 update plans available to this group. Amendments to 111-070-0015 extend the open enrollment timeframe and amendments to 111-070-0050 add a processing fee if the member declines the use of the electronic funds transfer and has a checking account.
Rules Coordinator: April Kelly
Address: Oregon Health Authority, Oregon Educators Benefit Board, 1225 Ferry St. SE, Salem, OR 97301
Telephone: (503) 378-6588

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Rule Caption: Establishes eligibility verification and reviews language under Operations rule

Date:	Time:	Location:
8-19-13	10 a.m.	1225 Ferry St.SE OEBB Boardroom Salem, OR 97301

Hearing Officer: OEBB Staff
Stat. Auth.: ORS 243.860–243.886

Stats. Implemented: ORS 243.864(1)(a)
Proposed Adoptions: 111-080-0055
Last Date for Comment: 8-31-13, Close of Business
Summary: Currently, limited eligibility review language exists in Division 40 and Division 50 under OEBB's Chapter 111 rules. 111-080-0055 establishes eligibility verification and reviews language in rule under OEBB's Operations rule which elaborates on the different types of verifications and reviews and the timeline for such reviews.
Rules Coordinator: April Kelly
Address: Oregon Health Authority, Oregon Educators Benefit Board, 1225 Ferry St. SE, Salem, OR 97301
Telephone: (503) 378-6588

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Oregon Health Insurance Exchange
Chapter 945

Rule Caption: Appeal of Exchange Eligibility Determinations

Date:	Time:	Location:
8-20-13	10 a.m.	16760 SW Upper Boones Ferry Rd., Suite 1000 Durham, OR 97224

Hearing Officer: Gregory Jolivette
Stat. Auth.: ORS 741.002
Stats. Implemented: ORS 741.500
Proposed Adoptions: 945-040-0100 – 945-040-170
Proposed Amendments: 945-040-0010
Last Date for Comment: 8-27-13, 5 p.m.
Summary: Establishes the process for appeals of Exchange eligibility determinations.
Rules Coordinator: Gregory Jolivette
Address: Oregon Health Insurance Exchange, 16760 SW Upper Boones Ferry Rd., Suite 200, Durham, OR 97224
Telephone: (503) 373-9406

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Oregon Liquor Control Commission
Chapter 845

Rule Caption: Amends two rules to implement statutory changes requiring service permits for new category of persons.

Date:	Time:	Location:
8-28-13	10 a.m.	9079 SE McLoughlin Blvd. Portland OR 97222

Hearing Officer: Annabelle Henry
Stat. Auth.: ORS 471, 471.030, 471.040, 471.190 & 471.730(1) & (5)
Stats. Implemented: ORS 471.190, 471.360, 471.365(2) & 471.375
Proposed Amendments: 845-009-0010, 845-009-0015
Last Date for Comment: 9-11-13, 5 p.m.
Summary: On May 10, 2013, the Commission initiated rulemaking to amend OAR 845-009-0010 (Service Permit Requirements) and OAR 845-009-0015 (Licensee and Authorized Person's Responsibility for Verifying Identification). Permanent rulemaking was initiated in order to comply with the statutory amendments enacted by House Bill 2443. On the same day, the Commission adopted temporary rules, effective May 10, 2013 through November 6, 2013, because House Bill 2443 includes an emergency clause making it effective upon passage. A public hearing was held on June 24, 2013. However, on June 26, 2013, the Governor signed Senate Bill 795 into law. Senate Bill 795 amends ORS 471.375 to allow service permittees who dispense malt beverages, wine or cider sold in securely covered containers to work while their applications are pending. Because Senate Bill 795 includes an emergency clause making it effective upon passage, the proposed amendments to OAR 845-009-0010 and OAR 845-009-0015 must be revised to reflect the new statutory language. The Commission will hold a second hearing to provide interested parties with an opportunity to comment on these additional revisions.
Rules Coordinator: Annabelle Henry
Address: Oregon Liquor Control Commission, 9079 SE McLoughlin Blvd., Portland, OR 97222
Telephone: (503) 872-5004

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Rule Caption: Affirms that the prohibition against self-service continues to apply to all persons.

Date:	Time:	Location:
8-27-13	10 a.m.	9079 SE McLoughlin Blvd. Portland, OR 97222

Hearing Officer: Annabelle Henry
Stat. Auth.: ORS 471, 471.030, 471.040 & 471.730(1) & (5)
Stats. Implemented: ORS 471.030, 471.040, 471.175, 471.178, 471.186, 471.200, 471.223, 471.227, 471.315(1)(a)(H), 471.351(1), 471.405(1), 471.408, 471.412, 471.675 & 471.730
Proposed Amendments: 845-006-0345
Last Date for Comment: 9-10-13, 5 p.m.
Summary: Section (1) of this rule prohibits a licensee or permittee from consuming an alcoholic beverage or being under the influence of intoxicants while on duty. The proposed amendments create a new section, labeled section (11), that prohibits "any person" from mixing, selling or serving an alcoholic beverage to himself or herself for on-premises consumption. The prohibition against self-service is not new; however, the amendments enacted by House Bill 2443 have changed the statutory bases for this prohibition. The proposed amendments affirm that the prohibitions against self-service continue to apply to all persons.
Rules Coordinator: Annabelle Henry
Address: Oregon Liquor Control Commission, 9079 SE McLoughlin Blvd., Portland, OR 97222
Telephone: (503) 872-5004

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Oregon Medical Board
Chapter 847

Rule Caption: Board member compensation
Stat. Auth.: ORS 677.235
Stats. Implemented: ORS 292.495 & 677.235
Proposed Adoptions: 847-003-0200
Last Date for Comment: 8-21-13, Close of Business
Summary: The proposed rule adoption establishes the compensation authorized for Board members.
Rules Coordinator: Nicole Krishnaswami
Address: Oregon Medical Board, 1500 SW 1st Ave., Suite 620, Portland, OR 97201
Telephone: (971) 673-2667

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Rule Caption: Expands Visiting Physician approval to physicians volunteering at community nonprofit organizations
Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.132 & 677.265
Proposed Amendments: 847-010-0066
Last Date for Comment: 8-21-13, Close of Business
Summary: The proposed rule amendment expands the visiting physician approval to include out-of-state physicians who provide health care services without compensation at a community nonprofit organization such as a county health fair. The proposed rule amendment also deletes the requirement for the visiting physician applicant to submit a curriculum vitae as the needed information is now gathered through the electronic application process.
Rules Coordinator: Nicole Krishnaswami
Address: Oregon Medical Board, 1500 SW 1st Ave., Suite 620, Portland, OR 97201
Telephone: (971) 673-2667

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Rule Caption: Merges the names of the two former national databanks into one
Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.265

Proposed Amendments: 847-008-0055
Last Date for Comment: 8-21-13, Close of Business
Summary: The proposed rule amendment reflects the merger of the two national databanks (formerly the National Practitioner Data Bank and the Health Integrity & Protection Data Bank) into one (now known as the National Practitioner Data Bank).
Rules Coordinator: Nicole Krishnaswami
Address: Oregon Medical Board, 1500 SW 1st Ave., Suite 620, Portland, OR 97201
Telephone: (971) 673-2667

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Rule Caption: Merges the names of the two former national databanks into one
Stat. Auth.: ORS 677.100, & 677.265
Stats. Implemented: ORS 677.100, 677.190 & 677.265
Proposed Amendments: 847-020-0150, 847-020-0185
Last Date for Comment: 8-21-13, Close of Business
Summary: The proposed rule amendment reflects the merger of the two national databanks (formerly the National Practitioner Data Bank and the Health Integrity & Protection Data Bank) into one (now known as the National Practitioner Data Bank).
Rules Coordinator: Nicole Krishnaswami
Address: Oregon Medical Board, 1500 SW 1st Ave., Suite 620, Portland, OR 97201
Telephone: (971) 673-2667

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Rule Caption: Merges the names of the two former national databanks into one
Stat. Auth.: ORS 677.115 & 677.265
Stats. Implemented: ORS 677.115 & 677.265
Proposed Amendments: 847-026-0010
Last Date for Comment: 8-21-13, Close of Business
Summary: The proposed rule amendment reflects the merger of the two national databanks (formerly the National Practitioner Data Bank and the Health Integrity & Protection Data Bank) into one (now known as the National Practitioner Data Bank).
Rules Coordinator: Nicole Krishnaswami
Address: Oregon Medical Board, 1500 SW 1st Ave., Suite 620, Portland, OR 97201
Telephone: (971) 673-2667

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Rule Caption: Memorializes the authority previously delegated to the Executive Director to issue Notices of Civil Penalty
Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.190, 677.205 & 677.265
Proposed Adoptions: 847-001-0040
Proposed Repeals: 847-001-0040(T)
Last Date for Comment: 8-21-13, Close of Business
Summary: The proposed rule adoption puts into administrative rule the authority that has been previously delegated by the Board to the Executive Director over approving and signing Notices of Civil Penalty for violation of Board administrative rules.
Rules Coordinator: Nicole Krishnaswami
Address: Oregon Medical Board, 1500 SW 1st Ave., Suite 620, Portland, OR 97201
Telephone: (971) 673-2667

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Rule Caption: Fee changes as approved
Stat. Auth.: ORS 181.534, 431.972, 676.410, 677.265 & 677.290
Stats. Implemented: ORS 181.534, 192.440, 431.972, 676.410, 677.265 & 677.290
Proposed Amendments: 847-005-0005
Proposed Repeals: 847-005-0005(T)
Last Date for Comment: 8-21-13, Close of Business
Summary: The proposed rule amendment reflects fees approved by the legislature for the 2013–15 biennial budget, including adjusted registration fees, a $100 application fee for a physician to supervise a physician assistant, a one-time surcharge for physician assistants, and a pass-through fee for the actual cost of criminal records checks on applicants or licensees.
Rules Coordinator: Nicole Krishnaswami
Address: Oregon Medical Board, 1500 SW 1st Ave., Suite 620, Portland, OR 97201
Telephone: (971) 673-2667

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Rule Caption: Memorializes the licensing authority previously delegated to the Executive Director and Medical Director
Stat. Auth.: ORS 677.235
Stats. Implemented: ORS 292.495 & 677.235
Proposed Adoptions: 847-008-0003
Proposed Repeals: 847-008-0003(T)
Last Date for Comment: 8-21-13, Close of Business
Summary: The proposed rule adoption puts into administrative rule the licensing authority that has been previously delegated by the Board to the Executive Director and Medical Director.
Rules Coordinator: Nicole Krishnaswami
Address: Oregon Medical Board, 1500 SW 1st Ave., Suite 620, Portland, OR 97201
Telephone: (971) 673-2667

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Rule Caption: Fee for criminal records checks as approved
Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 181.534, 677.100 & 677.265
Proposed Amendments: 847-008-0068
Proposed Repeals: 847-008-0068(T)
Last Date for Comment: 8-21-13, Close of Business
Summary: The proposed rule amendment specifies that the criminal records check cost will be passed through to the applicant or licensee as approved by the legislature in the 2013–15 budget.
Rules Coordinator: Nicole Krishnaswami
Address: Oregon Medical Board, 1500 SW 1st Ave., Suite 620, Portland, OR 97201
Telephone: (971) 673-2667

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Rule Caption: Corrects the licensing process for Limited License, Medical Faculty
Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.100 & 677.132
Proposed Amendments: 847-010-0063
Proposed Repeals: 847-010-0063(T)
Last Date for Comment: 8-21-13, Close of Business
Summary: The proposed rule amendment accurately reflects that the Limited License, Medical Faculty is approved weekly rather than quarterly as a result of the delegation of these license application approvals to the Executive Director in July 2010.
Rules Coordinator: Nicole Krishnaswami
Address: Oregon Medical Board, 1500 SW 1st Ave., Suite 620, Portland, OR 97201
Telephone: (971) 673-2667

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Rule Caption: Supervising physician application fee and physician assistant surcharge fee as approved
Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.205, 677.510 & 677.512
Proposed Amendments: 847-050-0027, 847-050-0042
Proposed Repeals: 847-050-0027(T), 847-050-0042(T)
Last Date for Comment: 8-21-13, Close of Business
Summary: As approved by the legislature in the 2013–15 budget, the proposed rule amendment specifies that there is a fee for the supervising physician application and implements a one-time surcharge for physician assistants renewing or applying for initial licensure in the 2014–15 licensure biennium.
Rules Coordinator: Nicole Krishnaswami

Address: Oregon Medical Board, 1500 SW 1st Ave., Suite 620, Portland, OR 97201
Telephone: (971) 673-2667

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Rule Caption: Drug dispensing, distribution and administration requirements
Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.010, 677.089, 677.510 & 677.515
Proposed Amendments: 847-015-0025
Last Date for Comment: 8-21-13, Close of Business
Summary: The proposed rule amendment establishes documentation standards for drugs dispensed, distributed or administered; requires provision of take-home instructions for drugs dispensed or distributed; clarifies that distribution, as defined by the Board of Pharmacy, is distinct from dispensing; and clarifies that a physician supervising a physician assistant with drug dispensing authority without first registering as a dispensing physician is a violation of the rule.
Rules Coordinator: Nicole Krishnaswami
Address: Oregon Medical Board, 1500 SW 1st Ave., Suite 620, Portland, OR 97201
Telephone: (971) 673-2667

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Rule Caption: Defines office-based procedures and clarifies provider qualifications and requirements
Stat. Auth.: ORS 677.265 & 679.255
Stats. Implemented: OAR 677.060, 677.085, 677.097 & 677.265
Proposed Adoptions: 847-017-0003, 847-017-0008, 847-017-0037
Proposed Amendments: 847-017-0000, 847-017-0005, 847-017-0010, 847-017-0015, 847-017-0020, 847-017-0025, 847-017-0030, 847-017-0035, 847-017-0040
Last Date for Comment: 8-21-13, Close of Business
Summary: The proposed rule amendments classify levels of office-based surgeries and set forth the corresponding requirements; reorganize and add new definitions; establish a standard of practice for licensees performing office-based surgery; set forth requirements for office-based surgery facilities; clarify the assessment and informed consent procedures prior to the performance of an office-based surgery; clarify the requirements for patient medical records; expand the emergency care and transfer protocol requirements; require reporting of specified office-based surgical adverse events; and contain general grammar and language housekeeping changes.
Rules Coordinator: Nicole Krishnaswami
Address: Oregon Medical Board, 1500 SW 1st Ave., Suite 620, Portland, OR 97201
Telephone: (971) 673-2667

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Oregon Public Employees Retirement System
Chapter 459

Rule Caption: Adopt new assumed rate and specify effective date of implementation.

Date:	Time:	Location:
8-27-13	3 p.m.	PERS Boardroom 11410 SW 68th Pkwy. Tigard, OR 97223

Hearing Officer: Daniel Rivas
Stat. Auth.: ORS 238.650 & 238A.450
Stats. Implemented: ORS 238 & 238A
Proposed Adoptions: 459-007-0007
Last Date for Comment: 9-3-13, 5 p.m.
Summary: ORS 238.255 provides the PERS Board shall determine an assumed interest rate. OAR 459-007-0001(2) states the "assumed rate" is "the actuarial assumed rate of return on investments as adopted by the Board for the most recent actuarial valuation." Currently, PERS does not have an administrative rule that sets forth the assumed rate or the effective date of any change to the assumed rate. The proposed rule adopts a new assumed rate and specifies when the assumed rate will be effective for PERS transactions.
Rules Coordinator: Daniel Rivas
Address: Oregon Public Employees Retirement System, PO Box 23700, Tigard, OR 97281
Telephone: (503) 603-7713

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Oregon State Lottery
Chapter 177

Rule Caption: Amends game matrix; Creates 30-year Jackpot annuity; Modifies prize accounts; Specifies when prizes become pari-mutuel.

Date:	Time:	Location:
8-16-13	2 p.m.	Oregon State Lottery 500 Airport Rd. SE Salem, OR 97301

Hearing Officer: Larry Trott
Stat. Auth.: ORS 461
Other Auth.: Oregon Constitution, Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.210. 461.220, 461.230 & 461.250
Proposed Amendments: 177-098-0010, 177-098-0020, 177-098-0030, 177-098-0040, 177-098-0050, 177-098-0060, 177-098-0110
Last Date for Comment: 8-16-13, 2:30 p.m.
Summary: The Oregon Lottery has filed a Notice of Proposed Rulemaking Hearing to amend the above referenced administrative rules for the Mega Millions game. The Mega Millions game is being updated with a new matrix and Megaplier multipliers which modify the odds of winning. It is anticipated that these changes will attract more players resulting in higher jackpots and more prize payments. Other amendments provide:

1. In the event the multiplier drawing does not occur prior to the Mega Millions drawing, the multiplier number will be a 5;
2. The Jackpot prize will be paid in thirty graduated annual payments increasing by 5% each year;
3. The creation of new prize reserve and prize pool accounts for funding of the various prizes; and
4. Circumstances under which prizes will become pari-mutuel are being modified.

These changes are necessary to implement the changes to the Mega Millions game rules made by the national organization that administers the multi-state Mega Millions game.
Rules Coordinator: Mark W. Hohlt
Address: Oregon State Lottery, 500 Airport Rd. SE, Salem, OR 97301
Telephone: (503) 540-1417

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Oregon University System, Eastern Oregon University
Chapter 579

Rule Caption: Repeal of the Eastern Oregon University Complaint and Grievance Procedures.
Stat. Auth.: ORS.351.060
Stats. Implemented: ORS 351.060
Proposed Repeals: 579-010-0006, 579-010-0011, 579-010-0016, 579-010-0021, 579-010-0026, 579-010-0030, 579-010-0035, 579-010-0040, Appendix A and Appendix B
Last Date for Comment: 8-24-13, 4 p.m.
Summary: The proposed repeal of the Eastern Oregon University (EOU) Grievance Procedures will allow EOU to establish a more clearly articulated student grievance procedure. Grievance procedures pertaining to employment are identified in both negotiated contracts and university handbook. Grievance procedures pertaining to discrimination, including sexual harassment is outlined in the EOU Affirmative Action plan and the Sexual Harassment policy.
Rules Coordinator: Teresa Carson-Mastrude
Address: Oregon University System, Eastern Oregon University, One University Blvd., Inlow Hall 202A, La Grande, OR 97850
Telephone: (541) 962-3773

Oregon Watershed Enhancement Board
Chapter 695

Rule Caption: Repeals outdated administrative rules established in 2007 for salmon season state of emergency grants
Stat. Auth.: ORS 541.906
Other Auth.: Governor's Executive Order Nos. 06-06, 06-07, & 08-10
Stats. Implemented: ORS 541.890–541.969
Proposed Repeals: 695-007-0010, 695-007-0020, 695-007-0030, 695-007-0040
Last Date for Comment: 8-22-13, 5 p.m.
Summary: Division 7 of OWEB's administrative rules was established in response to Governor Kulongoski's Executive Orders issued between 2006 and 2008 declaring Salmon Season States of Emergency. The rules established grant application and award criteria for restoration, inventory and data collection, outreach, and technical planning projects that created employment opportunities for displaced workers (primarily fishers) during the States of Emergency. The most recent of the Salmon Season State of Emergency addressed by Division 7 rules expired in May 2009, rendering the rules obsolete. No Salmon Season State of Emergency has been declared since 2009.

Furthermore, the subsequent adoption of Division 4 rules (i.e. OAR 695-004-0030 (2)) in 2009 gives the OWEB Board the ability to offer special grant types, such as the Salmon Season State of Emergency Grants. If a future State of Emergency is declared and the OWEB Board again decides to offer grants that provide opportunities to displaced workers, Division 4 rules allow the Board to publicly discuss and approve necessary guidance and criteria for special grant programs without amending or writing new administrative rules for each unique circumstance. The Division 4 rule renders the Division 7 rules redundant and unnecessary now and into the future.

Public comment will be accepted on the proposed rule repeal from August 1, 2013 through 5 p.m. on August 22, 2013. Copies of the rules proposed for repeal will be available by August 1, 2013 on OWEB's website (www.oregon.gov/OWEB/pages/admin_rules_statutes.aspx).
Rules Coordinator: Renee Davis-Born
Address: Oregon Watershed Enhancement Board, 775 Summer St. NE, Suite 360, Salem, OR 97301
Telephone: (503) 986-0029

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Parks and Recreation Department
Chapter 736

Rule Caption: Revise Camping Rates for State Parks

Date:	Time:	Location:
8-20-13	7 p.m.	South Beach State Park Meeting Yurt 5580 S. Coast Hwy. Newport, OR 97366
8-21-13	7 p.m.	Champoeg State Heritage Area Visitor Center 8239 Champoeg Road NE St. Paul, OR 97137
8-22-13	7 p.m.	The Cove Palisades State Park Crooked River Campground Program Area 7300 Jordan Rd. Culver OR 97734
8-23-13	7 p.m.	Wallowa Lake State Recreation Area Day Use Picnic Shelter 72214 Marina Ln. Joseph, OR 97846

Hearing Officer: Staff
Stat. Auth.: ORS 390.124
Stats. Implemented: ORS 390.111, 390.121 & 390.124
Proposed Amendments: 736-015-0006, 736-015-0010, 736-015-0015, 736-015-0020, 736-015-0026, 736-015-0030, 736-015-0035, 736-015-0040, 736-015-0043
Last Date for Comment: 8-30-13, 5 p.m.
Summary: Rules under OAR Chapter 736, divisions 15, Rates, establish rates for camping and day use in properties managed by the Oregon Parks and Recreation Department. The division also sets fee waivers for specific groups.

During the 2013 legislative session, OPRD received approval to increase camping rates. The proposed rule changes implement the legislatively approved fees and cover two additional items as follows:

(1) Limits foster family fee waivers to 14 days within a calendar month to make it consistent with other fee waiver programs; and

(2) Changes the fee structure for motorcycles in campsite to include up to two motorcycles for the extra vehicle fee, as opposed to just one motorcycle.

* Those who wish to make public comment during public hearings must register with the hearings officer on site by 7:30 PM on the day of the hearing.
Rules Coordinator: Vanessa DeMoe
Address: Parks and Recreation Department, 725 Summer St. NE, Suite C, Salem, OR 97301
Telephone: (503) 986-0719

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Secretary of State,
Corporation Division
Chapter 160

Rule Caption: Notaries Public
Stat. Auth.: 2013 OL Ch. 219 Sec. 26
Stats. Implemented: 2013 OL Ch. 219
Proposed Amendments: 160-100-0000 – 160-100-1150
Last Date for Comment: 8-22-13, 12 p.m.
Summary: These rules are updated to include electronic notarizations and electronic journals. These rules also update the notary name requirement to include the full legal name to be used for notarization, and the notary seal will be replaced with the stamping device and the stamp.
Rules Coordinator: Ginger Spotts
Address: Secretary of State, Corporation Division, 255 Capitol St. NE, Suite 151, Salem, OR 97310
Telephone: (503) 986-2333

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Veterinary Medical Examining Board
Chapter 875

Rule Caption: Deletes references to Euthanasia Task Force; adds definition of 'indirect supervision.'
Stat. Auth.: ORS 686.210
Stats. Implemented: ORS 475.190, 609.405, 686.130, 686.225 & 686.510
Proposed Amendments: 875-005-0005
Last Date for Comment: 8-30-13, Close of Business
Summary: Deletes definition of 'lethal drug' and 'Task Force' relative to the Euthanasia Task Force.

Adds definition of 'indirect supervision' companion to amendment of Division 30 that allows Certified Veterinary Technicians to perform duties outside veterinary facilities.
Rules Coordinator: Lori V. Makinen
Address: Veterinary Medical Examining Board, 800 NE Oregon St., Suite 407, Portland, OR 97232
Telephone: (971) 673-0224

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Rule Caption: Updates license application process, qualifications, CE requirements; increases license fees, eliminates inactive license.
Stat. Auth.: ORS 686.210
Stats. Implemented: ORS 686.020, 686.040, 686.045, 686.065, 686.075, 686.085. 686.095, 686.110, 686.255, 686.410 & 686.420
Proposed Amendments: 875-010, 875-010-0000
Last Date for Comment: 8-30-13, Close of Business

Summary: Updates qualifications for veterinary licenses, student interns and veterinary interns; license renewal procedures. Adds requirements for official transcript for application; expands on-line options for Continuing Education; eliminates inactive license category; increases license fee to $150.
Rules Coordinator: Lori V. Makinen
Address: Veterinary Medical Examining Board, 800 NE Oregon St., Suite 407, Portland, OR 97232
Telephone: (971) 673-0224

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Rule Caption: Adds requirements for physical examination and medical records; requires provision of prescription if requested.
Stat. Auth.: ORS 686.210
Stats. Implemented: ORS 686.020, 686.040, 686.130 & 686.370
Proposed Amendments: Rules in 875-015
Last Date for Comment: 8-30-13, Close of Business
Summary: Adds requirement to evaluate and document patient's integumentary system, allows estimate of weight for large animals, and requires licensee to provide a prescription for biological and drugs if requested by the client.
Rules Coordinator: Lori V. Makinen
Address: Veterinary Medical Examining Board, 800 NE Oregon St., Suite 407, Portland, OR 97232
Telephone: (971) 673-0224

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Rule Caption: Eliminates obsolete VTNE criteria; adds indirect supervision; eliminates inactive license, increases license fee.
Stat. Auth.: ORS 686.210
Stats. Implemented: ORS 686.210, 686.225, 686.350 & 686.370
Proposed Amendments: Rules in 875-030
Last Date for Comment: 8-30-13, Close of Business
Summary: Deletes obsolete criteria for on-the-job eligibility for the Veterinary Technician National Exam; adds indirect supervision to allow CVT duties away from veterinary facility; eliminates the inactive license category; raises license and renewal fee to $35.
Rules Coordinator: Lori V. Makinen
Address: Veterinary Medical Examining Board, 800 NE Oregon St., Suite 407, Portland, OR 97232
Telephone: (971) 673-0224

Appraiser Certification and Licensure Board
Chapter 161

Rule Caption: Adoption of temporary rules regarding application process, and suspension of rule regarding reciprocity.
Adm. Order No.: ACLB 3-2013(Temp)
Filed with Sec. of State: 6-28-2013
Certified to be Effective: 7-1-13 thru 12-26-13
Notice Publication Date:
Rules Amended: 161-010-0080, 161-015-0025, 161-015-0030
Rules Suspended: 161-050-0050
Subject: Temporarily amends Oregon Administrative Rule 161, Division 010, Rule 0080, regarding continuing education requirements for appraiser assistant renewal; Division 015, Rule 0025, regarding application from out-of-state credential holder; Rule 0030 regarding submission of license or certificate application; and temporary suspension of Division 050, Rule 0050 regarding reciprocity.
Rules Coordinator: Karen Turnbow—(503) 485-2555

161-010-0080
Appraiser Assistant Registration — Application and Renewal Requirements

(1) A person desiring to participate in an appraiser training program must register with the Board and work under the direct supervision of one or more licensees who are in good standing with the Board, has been certified with the Board for a minimum of 24 months, and has a supervising appraiser endorsement. Experience gained prior to registration will be not accepted.

(2) Prior to registering with the Board, an Appraiser Assistant applicant must:

(a) Complete 75 hours of qualifying education in the following categories and successfully pass the applicable final examinations:

(A) 15-hour Appraisal Foundation's National USPAP course, or its equivalent, within two (2) years preceding the date of application;

(B) 30-hour Basic Appraisal Principles course within five (5) years preceding the date of application. The five-year requirement does not apply to licensees that register as an Appraiser Assistant to upgrade their license or certificate;

(C) 30-hour Basic Appraisal Procedures course within five (5) years preceding the date of application. The five-year requirement does not apply to licensees that register as an Appraiser Assistant to upgrade their license or certificate; and

(b) Make arrangements with one or more licensees who agree to directly supervise their real estate appraisal activities.

(c) Attend a four-hour Board approved Supervising Appraiser/ Appraiser Assistant Training Course and successfully pass the final exam.

(3) The applicant must submit an Appraiser Assistant Registration Application that meets the requirements of OAR 161-015-0010(1) through (5) and includes a non-refundable application fee and a copy of their supervising appraiser's endorsement as described on the application form.

(4) An applicant must be at least 18 years of age.

(5) An applicant must be a citizen of the United States or have the legal authority to work in the United States.

(6) The Appraiser Assistant Registration must be renewed on an annual basis. The renewal application must be submitted on the prescribed form and include the following:

(a) Verification of successful completion of the Appraisal Foundation's National USPAP Update course or its equivalent, if applicable (required during their second year and every two years thereafter);

(b) Verification of successful completion of no less than fourteen hours of qualifying or continuing education. The fourteen education hours may include the USPAP Update course and must be obtained on or after the date their last registration was issued.

(7) During the period beginning on the day following the expiration date of the registration, and ending on the date of the renewal of the registration, an Appraiser Assistant will not receive experience credit for any experience accrued during the lapse in registration. If the Appraiser Assistant fails to renew the registration within one year from the expiration date, the registration is terminated and a new application must be submitted pursuant to ORS 161-010-0080.

(8) Appraiser Assistants on active duty with the United States Armed Forces at the time of renewal may, upon written request to the Board, be provided a military deferral allowing for their otherwise complete application, including fee and evidence of continuing education, to be considered timely if received by the Board within 180 days of release from active duty.

(9) An applicant may submit a written request to withdraw their application at any time prior to an official action being taken by the Board.

Stat. Auth.: ORS 674.305(8) & 674.310
Stats. Implemented: ORS 674
Hist.: ACLB 8-1991(Temp), f. & cert. ef. 12-31-91; ACLB 2-1992, f. & cert. ef. 4-30-92; ACLB 4-1993(Temp), f. & cert. ef. 6-25-93; ACLB 1-1994, f. & cert. ef. 2-1-94; ACLB 3-1996, f. & cert. ef. 2-13-96; ACLB 1-1998, f. 6-24-98, cert. ef. 7-1-98; ACLB 1-2002, f. & cert. ef. 2-26-02; ACLB 3-2003, f. & cert. ef. 5-1-03; ACLB 2-2004, f. 5-25-04, cert., ef. 6-1-04; ACLB 3-2005, f. & cert. ef 7-22-05; ACLB 4-2005, f. & cert. ef. 11-2-05; ACLB 2-2006, f. & cert. ef. 7-26-06; ACLB 1-2007, f. & cert. ef. 2-9-07; ACLB 1-2008, f. & cert. ef. 5-13-08; ACLB 2-2008(Temp), f. & cert. ef. 8-6-08 thru 2-1-09; ACLB 3-2008, f. & cert. ef. 8-13-08; ACLB 2-2012(Temp), f. & cert. ef. 8-3-12 thru 1-30-13; ACLB 1-2013, f. 1-30-13, cert. ef. 1-31-13; ACLB 3-2013(Temp), f. 6-28-13, cert. ef. 7-1-13 thru 12-26-13

161-015-0025
Application from Out-of-State Credential Holder

(1) The Board may recognize and accept the education and experience of applicants who hold a license or certificate obtained from another state. The out-of-state license or certificate must be active and the applicant must be in good standing in all states in which they are licensed and/or certified.

(2) An applicant may apply for an Oregon real property appraiser license or certificate at a level consistent with their out-of-state license or certificate provided that:

(a) The appraiser licensing program of the other state is in compliance with the provisions of Title XI of the Financial Institutions Reform, Recovery and Enforcement Act of 1989 {12U.S.C.3331-3351} as amended by the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010; and

(b) The other state has credentialing requirements that meet or exceeds those of Oregon.

(3) Each out-of-state credential holder applying for an Oregon real estate appraiser license or certificate shall:

(a) Be at least 18 years of age;

(b) Be identified on the National Registry of the Appraisal Subcommittee as an active licensed or certified real property appraiser that currently conforms to the AQB criteria;

(c) Submit an application for a license or certificate on a form prescribed by the Board as set forth in OAR 161-015-0030; and

(d) Be subjected to a background check pursuant to OAR 161-030-0000.

Stat. Auth.: ORS 674.305(8) & 674.310
Stats. Implemented: ORS 674
Hist.: ACLB 3-2008, f. & cert. ef. 8-13-08; ACLB 1-2010(Temp), f. 1-29-10, cert. ef. 2-1-10 thru 7-27-10; ACLB 2-2010, f. & cert. ef. 4-23-10; ACLB 2-2012(Temp), f. & cert. ef. 8-3-12 thru 1-30-13; ACLB 1-2013, f. 1-30-13, cert. ef. 1-31-13; ACLB 3-2013(Temp), f. 6-28-13, cert. ef. 7-1-13 thru 12-26-13

161-015-0030
Submission of License or Certificate Application

(1) Each application must be accompanied by a non-refundable application fee.

(2) An application that is not properly completed, does not contain all the required information, or is not accompanied by the required fee will be deferred. An application will also be considered incomplete if the check for payment of the required fees is dishonored;

(3) The application will be reviewed to determine whether the applicant has sufficient education and experience and is otherwise qualified to sit for the examination;

(4) An applicant who is not a resident of the State of Oregon must submit with the application, an irrevocable consent to service form appointing the Administrator of the Board as agent for service of process as provided in these rules, if, in an action against the applicant in a court of this state arising out of the applicant's activities as a licensed or certified appraiser, the plaintiff cannot, in the exercise of due diligence, effect personal service upon the applicant.

(5) An applicant must be a citizen of the United States or have the legal authority to work in the United States.

(6) An out-of-state credential holder applying for an Oregon real estate appraiser license or certificate must have successfully passed an AQB approved examination at a level consistent with the appraiser category applied for in the State of Oregon.

(7) Applicants for licensure or certification must have a license history submitted directly to the Board office from each state in which he or she has ever been licensed or certified, or the Board may obtain a National Registry Appraiser License History report. License histories must be received by the board within thirty (30) days of receipt of application.

Applicants must be in good standing in all states in which they are licensed or certified or the application will be denied.

(8) Upon application approval, if applicable, the applicant is notified that they are approved to sit for the examination. Upon successful completion of the examination, the Board will notify the appraiser and within one year of the notification, the applicant must submit the ACLB License/Certificate Request form with the appropriate certification and national registry fees, requesting that their license/certificate be issued. The Administrator issues the license/certificate to the applicant. The appraiser's name is submitted to the FFIEC Appraisal Subcommittee for inclusion on the Federal Registry.

(9) Upon issuance of a license or certificate, consistent with the scope of practice as provided in OAR 161-025-0000 and 161-025-0005, the appraiser is authorized to conduct real estate appraisal activity between the date of the issuance of the license or certificate, and the expiration date of the license or certificate, unless sooner revoked or suspended. No more than one license or certificate shall be issued and outstanding to, or in favor of, any appraiser at one time.

(10) An applicant may submit a written request to withdraw their application at any time prior to an official action being taken by the board. An official action may include, but is not limited to, a notice of proposed denial of application.

Stat. Auth.: ORS 674.305(8) & 674.310
Stats. Implemented: ORS 674
Hist.: ACLB 4-1991(Temp), f. & cert. ef. 8-29-91; ACLB 8-1991(Temp), f. & cert. ef. 12-31-91; ACLB 2-1992, f. & cert. ef. 4-30-92; ACLB 1-1994, f. & cert. ef. 2-1-94; ACLB 1-1998, f. 6-24-98, cert. ef. 7-1-98; ACLB 2-1999, f. & cert. ef. 4-20-99; ACLB 1-2000, f. & cert. ef. 2-29-00; ACLB 1-2002, f. & cert. ef. 2-26-02; ACLB 6-2003, f. & cert. ef. 11-24-03; ACLB 4-2005, f. & cert. ef. 11-2-05; ACLB 1-2007, f. & cert. ef. 2-9-07; ACLB 4-2007, f. 11-1-07, cert. ef. 1-1-08; ACLB 3-2008, f. & cert. ef. 8-13-08; ACLB 1-2010(Temp), f. 1-29-10, cert. ef. 2-1-10 thru 7-27-10; ACLB 2-2010, f. & cert. ef. 4-23-10; ACLB 2-2012(Temp), f. & cert. ef. 8-3-12 thru 1-30-13; ACLB 1-2013, f. 1-30-13, cert. ef. 1-31-13; ACLB 3-2013(Temp), f. 6-28-13, cert. ef. 7-1-13 thru 12-26-13

161-050-0050
Reciprocity

(1) The Administrator of the Board may enter into reciprocal agreements with other states in accordance with the following procedures:

(a) The Administrator shall determine that the standards, qualifications and examinations for the licensing and certifying of real estate appraisers in the other states are substantially similar to those in Oregon;

(b) The Administrator shall obtain the approval of the Board before entering into the agreement.

(2) Reciprocal agreements shall provide that the two states may issue licenses or certificates without examination, to license or certificate holders of the other state, upon payment of a mutually agreed upon fee, proof of current certificate and a certified letter of good standing from the other state.

(3) A reciprocal licensee shall comply with all statutes and rules governing licensed and certified appraisers in Oregon. Each reciprocal licensee shall immediately notify the Administrator of any disciplinary action taken in any other state in which the person holds a license or certificate.

(4) The Administrator may terminate a reciprocal agreement, with approval of the Board, if the administrator finds that the other state:

(a) Is not assisting the Administrator in enforcement activity for the protection of Oregon consumers;

(b) Is not maintaining and enforcing standards, qualifications, and examinations substantially similar to those of this state.

(5) Upon termination of a reciprocal agreement with another state, the Administrator may deny the issuance of a reciprocal license or certificate, or revoke a current reciprocal license or certificate from that state. Applicants, license and certificate holders from that state must then apply for a license or certificate in the same manner as other Oregon applicants.

(6) Reciprocal certificates are issued at the same level of certification as in the applicant's state.

(7) For purposes of this rule, "substantially similar" means that the other state's minimum standards qualifications for appraisal experience and education, and examinations meet the standards established by the Board as set forth in OAR 161, Division 10.

(8) Applications for a reciprocal license or certificate shall be processed in accordance with the written reciprocal agreement between the Board and the applicant's resident state.

Stat. Auth.: ORS 183.341, 674.305 & 674.310
Stats. Implemented: ORS 674
Hist.: ACLB 3-1994, f. & cert. ef. 5-2-94; ACLB 1-1998, f. 6-24-98, cert. ef. 7-1-98; ACLB 1-2002, f. & cert. ef. 2-26-02; ACLB 3-2003, f. & cert. ef. 5-1-03; ACLB 6-2003, f. & cert. ef. 11-24-03; ACLB 1-2010(Temp), f. 1-29-10, cert. ef. 2-1-10 thru 7-27-10; ACLB 2-2010, f. & cert. ef. 4-23-10; ACLB 2-2012(Temp), f. & cert. ef. 8-3-12 thru 1-30-13; ACLB 1-2013, f. 1-30-13, cert. ef. 1-31-13; Suspended by ACLB 3-2013(Temp), f. 6-28-13, cert. ef. 7-1-13 thru 12-26-13

Board of Examiners for Engineering and Land Surveying
Chapter 820

Rule Caption: Adopt Board's 2013–2015 budget and permanently amend rule related to CPD requirements for CWREs.
Adm. Order No.: BEELS 3-2013
Filed with Sec. of State: 6-17-2013
Certified to be Effective: 6-17-13
Notice Publication Date: 4-1-2013
Rules Adopted: 820-050-0001
Rules Amended: 820-010-0325
Rules Repealed: 820-050-0001(T)
Subject: OAR 820-050-0001 — Adopts the language to clarify the professional development requirements for Certified Water Right Examiners. Repeals the temporary rule.

OAR 820-010-0325 — Adopts the budget of the Board for the 2013-2015 biennium.
Rules Coordinator: Mari Lopez—(503) 362-2666, ext. 26

820-010-0325
Budget

The amount of $3,000,000 is established for the biennium beginning July 1, 2013, as the intended limit for payment of expenses from fees, moneys or other revenue, including miscellaneous receipts, collected or received by the Board.

Stat. Auth.: ORS 182.462, 670.310, 672.155 & 672.255
Stats. Implemented: ORS 672.002 - 672.325
Hist.: BEELS 1-1999, f. 5-27-99, cert. ef. 7-1-99; BEELS 1-2001, f. & cert. ef. 5-22-01; BEELS 2-2002, f. & cert. ef. 5-15-02; BEELS 4-2003, f. 5-14-03, cert. ef. 7-1-03; BEELS 2-2004, f. & cert. ef. 7-14-04; BEELS 2-2005(Temp), f. & cert. ef. 6-9-05 thru 12-5-05; BEELS 4-2005, f. & cert. ef. 9-23-05; BEELS 1-2007(Temp), f. & cert. ef. 3-23-07 thru 6-30-07; Administrative correction, 7-15-07; BEELS 1-2008, f. & cert. ef. 3-12-08; BEELS 1-2009, f. & cert. ef. 5-15-09; BEELS 2-2011, f. & cert. ef. 5-12-11; BEELS 3-2013, f. & cert. ef. 6-17-13

820-050-0001
Continuing Professional Development — Certified Water Right Examiner (CWRE)

The purpose of professional development requirements is to demonstrate a continuing level of competency of certified water right examiners (CWRE).

(1) Requirements:

(a) A Registered Geologist that holds certification as a CWRE is required to obtain 10 professional development hour (PDH) units during the current biennial renewal period in order to renew for the next biennial renewal period.

(b) Every CWRE will report their PDH units on the Continuing Professional Development (CPD) Organizational form and submit to the Board office with the renewal form and fee. The CPD Organizational form must be completed in its entirety.

(c) Supporting documentation to verify the PDH units recorded on the CPD Organizational form must be submitted to the Board office when requested to participate in an audit. Supporting documentation may include, but are not limited to:

(A) Completion certificate(s);

(B) Paid receipt(s);

(C) Attendance log;

(D) Other documents supporting evidence of attendance.

(d) The CPD Organizational form and supporting documentation must be submitted to the Board in English or translated to English.

(e) Records must be retained for five (5) years.

(2) PDH units must be obtained in qualifying activities related to the individual's certification. A qualifying activity is any course or activity with a clear purpose and objective which improves, or expands the skills and knowledge relevant to the professional activities of a certified water right examiner as defined in ORS Chapter 537 and OAR Chapter 690.

(3) Non-qualifying activities may include, but are not limited to:

(a) Regular employment;

(b) Personal self improvement;

(c) Equipment demonstrations or trade show displays;

(d) Enrollment without attendance at courses, seminars, etc.

(e) Repetitive attendance at the same course;

(f) Repetitive teaching of the same course;

(g) Attending committee meetings or general business meetings of any organization;

(h) Taking professional or required examinations.

(4) Units — The conversion of other units of credit to PDH units is as follows:

(a) 1 College Semester hour equals 45 PDH;

(b) 1 College Quarter hour equals 30 PDH;

(c) 1 Continuing Education unit equals 10 PDH.

(5) Sources of PDH units — One (1) PDH unit may be obtained for each contact hour of instruction or presentation. Unless otherwise noted, there is no maximum amount of PDH units a CWRE may earn per biennial renewal period. Sources of PDH units include, but are not limited to the following:

(a) Successful completion of college courses;

(b) Successful completion of short courses, tutorials, correspondence, web based courses, televised and videotaped courses;

(c) Active participation in seminars, in-house courses, workshops, and professional conventions;

(d) Teaching or instructing a course, seminar, or workshop one time only. (This does not apply to full-time faculty teaching college courses);

(e) Authoring or co-authoring published papers, articles or books. Maximum of 3 PDH units per biennial renewal period;

(f) Active participation in professional or technical society, committee, or board. Maximum of 2 PDH units per biennial renewal period;

(g) Self study. Maximum of 2 PDH units per biennial renewal period;

(h) Non-technical educational activities related to employment.

(6) Determination of Credit — Credit determination for activities is the responsibility of the CWRE and is subject to review by the Board. The Board has final authority with respect to approval of courses, credit, PDH units for courses and other methods of earning credit.

(7) If a CWRE exceeds the requirement in any renewal period, a maximum of 5 PDH units in courses/activities may be carried forward into the next renewal period.

(8) Delinquent, retired or inactive certificate holders must provide evidence of holding active registration as a professional engineer, professional land surveyor, registered geologist, in addition to completing the PDH requirements as outlined in OAR 820-010-0520 in order to attain active status.

Stat. Auth.: ORS 670.310 & 672.255
Stats. Implemented: ORS 672.002 - 672.375
Hist.: BEELS 2-2013(Temp), f. & cert. ef. 3-18-13 thru 7-15-13; BEELS 3-2013, f. & cert. ef. 6-17-13

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Rule Caption: Amend language to be consistent with the enabling statutes.
Adm. Order No.: BEELS 4-2013(Temp)
Filed with Sec. of State: 7-10-2013
Certified to be Effective: 7-10-13 thru 1-6-14
Notice Publication Date:
Rules Amended: 820-010-0225, 820-010-0226
Subject: Revises the language in OAR 820-010-0225 and 820-010-0226 so that they are consistent with the language contained in ORS 670.010 and 670.020.
Rules Coordinator: Mari Lopez—(503) 362-2666, ext. 26

820-010-0225
Educational Qualifications to Take the Fundamentals of Engineering (FE) Examination for Enrollment as an Engineering Intern (EI)

Applicants for admission to examination for enrollment as an EI will be required to submit the following evidence to show eligibility to take the FE examination:

(1) Official transcripts that document the degree and date awarded, demonstrating completion of an engineering curriculum satisfactory to the Board, as described in (3) below.

(2) If taking the examination prior to graduation, a statement signed by an official from the school, university or college that all work necessary to obtain a degree in a curriculum satisfactory to the Board has been or will be completed within four months after the first day of the month following the examination as provided in ORS 670.010. For April examinations, the degree must be completed no later than September 1 of that year. For October examinations, the degree must be completed no later than March 1 of the following year. Official transcript(s) that document the degree and date awarded, or an affidavit from the registrar or administrative head of the school, college, or university, which verifies date and completion of the qualifying degree, must also be received within four months after the first day of the month following the examination, as provided in 670.020. Completing the degree and providing satisfactory evidence of completion, within the required time period is necessary for the examination to be considered completed, to release examination scores and to allow enrollment as an EI. When the degree is not completed and the official transcript(s) or affidavit(s) that documents the degree and date awarded is not received within four months after the first day of the month following the examination, the application shall be considered withdrawn. This rule shall apply to applications from the April 2013 examination administration forward.

(3) For entrance to the FE examination, a curriculum satisfactory to the Board shall include:

(a) Graduation from an EAC of ABET accredited engineering program;

(b) Graduation from a TAC of ABET baccalaureate engineering program;

(c) Graduation from an ACCE accredited four-year baccalaureate construction engineering management program;

(d) Graduation from a graduate degree program in engineering at a college or university that has an EAC of ABET accredited undergraduate degree program in the same field as the graduate degree program, combined with completion of 21 semester/32 quarter hours of engineering related technical course work. The courses shall include at least six of the following nine subjects: Differential Equations, Physics, Statistics, Statics, Dynamics, Thermodynamics, Fluid Mechanics, Electrical Fundamentals and Strength of Materials.

(e) Graduation from TAC of ABET accredited two-year Engineering Technology program or graduation from a two-year Associate of Applied Science program in Engineering Technology that includes the following:

(A) A total of at least 64 semester/96 quarter hours;

(B) At least 32 semester/48 quarter hours in technical courses. (Skills and knowledge of appropriate methods, procedures and techniques; experience in carrying out established engineering procedures);

(C) At least 16 semester/24 quarter hours in math and science, including:

(i) 4 semester/6 quarter hours in basic science (physics, chemistry, earth and life sciences);

(ii) 8 semester/12 quarter hours in mathematics (not including courses below the level of college algebra or courses in computer programming);

(D) At least 9 semester/13 quarter hours in social science, humanities and communications; and

(E) In addition to the educational requirements set forth in paragraph (e) of subsection (3), graduates from two-year programs shall complete two or more years of engineering work before qualifying to take the FE examination for enrollment as an EI. In the alternative, graduates from two-year programs may complete additional course work consisting of 21 semester/32 quarter hours in Differential Equations, Physics, Statistics, Statics, Dynamics, Thermodynamics, Fluid Mechanics, Electrical Fundamentals and Strength of Materials.

(f) Completion of a curriculum that the Board finds has adequately prepared the application for enrollment as an EI.

Stat. Auth.: ORS 670.310 & 672.255
Stats. Implemented: ORS 672.002 - 672.325
Hist.: EE 13, f. 3-29-72, ef. 4-15-72; EE 16, f. 3-5-74, ef. 3-25-74; EE 20, f. & ef. 12-15-77; EE 1-1986, f. 2-4-86, ef. 2-15-86; EE 1-1992, f. & cert. ef. 2-3-92; EE 1-1995, f. 8-15-95, cert. ef. 9-1-95; EE 2-1996, f. & cert. ef. 10-3-96; BEELS 1-1998, f. & cert. ef. 2-10-98; BEELS 1-1999, f. 5-27-99, cert. ef. 7-1-99; BEELS 1-2001, f. & cert. ef. 5-22-01; BEELS 1-2004, f. & cert. ef. 1-26-04; BEELS 2-2006, f. & cert. ef. 11-21-06; BEELS 2-2008, f. & cert. ef. 7-9-08; BEELS 2-2009, f. & cert. ef. 11-13-09; BEELS 4-2012, f. & cert. ef. 9-14-12; BEELS 1-2013, f. & cert. ef. 3-13-13; BEELS 4-2013(Temp), f. & cert. ef. 7-10-13 thru 1-6-14

820-010-0226
Educational Qualifications to Take the Fundamentals of Land Surveying (FLS) Examination for Enrollment as a Land Surveying Intern (LSI)

Applicants for admission to examination for enrollment as an LSI will be required to submit the following evidence to show eligibility to take the FLS examination:

(1) Official transcripts that document the degree and date awarded, demonstrating completion of a land surveying curriculum satisfactory to the Board, as described in (3) below.

(2) If taking the examination prior to graduation, a statement signed by an official from the school, university or college that all work necessary to obtain a degree in a curriculum satisfactory to the Board has been or will be completed within four months after the first day of the month following the examination as provided in ORS 670.010. For April examinations, the degree must be completed no later than September 1 of that year. For October examinations, the degree must be completed no later than March 1 of the following year. Official transcript(s) that document the degree and date awarded, or an affidavit from the registrar or administrative head of the school, college, or university, which verifies date and completion of the

qualifying degree, must also be received within four months after the first day of the month following the examination, as provided in 670.020. Completing the degree and providing satisfactory evidence of completion, within the required time period, is necessary for the examination to be considered completed, to release examination scores and to allow enrollment as an LSI. When the degree is not completed and the official transcript(s) or affidavit(s) that documents the degree and date awarded is not received within our months after the first day of the month following the examination, the application shall be considered withdrawn. This rule shall apply to applications from the April 2013 examination administration forward.

(3) For entrance to the FLS Examination, a curriculum satisfactory to the Board shall include:

(a) Graduation from an EAC of ABET accredited four-year baccalaureate land surveying program;

(b) Graduation from an ASAC of ABET accredited four-year baccalaureate land surveying program;

(c) Graduation from a TAC of ABET accredited four-your baccalaureate land surveying program;

(d) Graduation from an EAC of ABET accredited four-year baccalaureate engineering program with 11 semester/16 quarter hours of surveying instruction and surveying law.

(e) Graduation from a TAC of ABET accredited four-year baccalaureate engineering program with 11 semester/16 quarter hours of surveying instruction and surveying law.

(f) Graduation from an ACCE accredited four-year baccalaureate engineering program with 11 semester/16 quarter hours of surveying instruction and surveying law.

(g) Graduation from a graduate degree program in land surveying at a college or university that has an ABET accredited undergraduate degree program in the same field, combined with completion of 11 semester/16 quarter hours of surveying instruction.

(h) Graduation from an ASAC of ABET accredited two-year Surveying Technology program, a TAC of ABET accredited two-year Surveying Technology program, or a two-year Association of Applied Science program in Surveying Technology or Engineering Technology that includes the following:

(A) A total of at least 64 semester/96 quarter hours;

(B) At least 32 semester/48 quarter hours in technical courses, of which a minimum of 11 semester/16 quarter hours shall be in surveying instruction;

(C) At least 16 semester/24 quarter hours in subjects such as math, science, basic electricity, hydraulics, road design, construction management and estimating engineering economics with college level algebra, trigonometry and statistics;

(D) At least 9 semester/13 quarter hours in social science, humanities and communications; and

(E) In addition to the educational requirements set forth in paragraph (h) of subsection (3), graduates from two-year education programs shall complete two or more years of active practice in land surveying work before qualifying to take the FLS examination for enrollment as an LSI. Graduation from a degree program related to engineering or land surveying that includes the following:

(i) 21 semester/32 quarter hours of coursework with a direct geomatics focus that requires the application of geomatics knowledge and skills. One of these courses must be surveying law related;

(ii) 27 semester/40 quarter hours that requires the application of mathematics for problem solving. At least one of these courses must focus on the application of differential and integral calculus;

(iii) 24 semester/35 quarter hours related to physical and natural science with laboratory applications; and

(iv) 4 semester/6 quarter hours of capstone or integrating experience that develops student competencies in applying both technical and nontechnical skills in solving problems.

(i) Completion of a curriculum that the Board finds adequately prepared the applicant for enrollment as an LSI.

Stat. Auth.: ORS 670.310 & 672.255

Stats. Implemented: ORS 672.002 - 672.325

Hist.: BEELS 2-2006, f. & cert. ef. 11-21-06; BEELS 2-2008, f. & cert. ef. 7-9-08; BEELS 2-2009, f. & cert. ef. 11-13-09; BEELS 4-2012, f. & cert. ef. 9-14-12; BEELS 1-2013, f. & cert. ef. 3-13-13; BEELS 4-2013(Temp), f. & cert. ef. 7-10-13 thru 1-6-14

Board of Examiners for Speech-Language Pathology and Audiology
Chapter 335

Rule Caption: Revise fee schedule per Legislatively Approved Budget; Implement temporary licenses effective July 1, 2013.
Adm. Order No.: SPA 3-2013(Temp)
Filed with Sec. of State: 6-28-2013
Certified to be Effective: 7-1-13 thru 12-28-13
Notice Publication Date:
Rules Adopted: 335-085-0010
Rules Amended: 335-060-0005, 335-060-0010
Subject: Implements fee schedule changes approved by the 2013 Legislature as part of the 2013-15 budget for the Board of Examiners for Speech-Language Pathology & Audiology.

Implements temporary licenses for specific purposes, as authorized in ORS 681.285 by the 2011 Legislature.
Rules Coordinator: Sandy Leybold—(971) 673-0220

335-060-0005
Definitions

(1) An Inactive License or Certificate may be obtained by those otherwise qualified individuals who meet the conditions for exemption from licensure under ORS 681.230, or do not require a license under 681.250 or a certificate under 681.360.

(2) A Conditional License is a license certificate issued by the Board to applicants who have completed degree requirements in OAR 335-060-0006, and are engaged in post-graduate supervised clinical experience until they obtain regular licensure. The examination is not required for a conditional license.

(3) Equivalent credentials for licensure are defined as follows:

(a) For regular licenses in speech-language pathology, if completing a doctoral program in which a master's degree has not been conferred, an applicant must submit a transcript showing completion of course work equivalent to, or exceeding, a master's degree that meets the requirements in OAR 335-060-0006. In addition to the transcript, the Board may require a letter from the academic department chair or program director documenting that the applicant has completed coursework equivalent to or exceeding a master's degree.

(b) For applicants for conditional licenses in speech-language pathology or initial licenses in audiology, when the applicant has completed all degree requirements, but the university is not scheduled to confer the degree for more than 30 days after the completion of all degree requirements, the Board will accept a letter from the university registrar, documenting that the applicant has completed all degree requirements, and has been approved to receive the degree, and issue a temporary license for up to 90 days. An official transcript showing the conferral of the degree must be submitted within 60 days of issuance of the temporary license.

(c) For applicants who completed their professional training in speech pathology or audiology outside of the United States, the Board requires a determination letter from a credential evaluation service approved by the American Speech-Language Hearing Association to determine equivalency to a master's degree or doctoral degree issued by an accredited program.

(d) Applicants for licensure or certification educated in foreign countries must submit documentation that course work was completed in an institution of higher education that is regionally accredited or recognized by the appropriate regulatory authority for that country.

(4) For the purposes of licensing speech-language pathologists under ORS 681.260 or audiologists under 681.264, and for purposes of student placement in supervised field work under 681.230:

(a) The "accrediting organization" that approves graduate programs is the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) of the American Speech-Language-Hearing Association.

(b) All graduate or undergraduate coursework must be completed at an institution of higher education that is regionally accredited by one of the following:

(A) Commission of Higher Education, Middle States Association of Colleges and Schools;

(B) Commission on Institutions of Higher Education, New England Association of Schools and Colleges;

(C) Commission on Institutions of Higher Education, North Central Association of Colleges and Schools;

(D) Commission on Colleges, Northwest Association of Schools and Colleges;

(E) Commission on Colleges, Southern Association of Colleges and Schools;

(F) Accrediting Commission for Senior Colleges and Universities, Western Association of Schools and Colleges.

Stat. Auth.: ORS 681.340, 681.360, 681.420 & 681.460
Stats. Implemented: ORS 681.460
Hist.: SPA 1-2001, f. & cert. ef. 3-12-01; SPA 1-2002(Temp), f. 11-8-02, cert. ef. 12-1-02 thru 5-1-03; SPA 1-2003, f. & cert. ef. 5-7-03; SPA 4-2006, f. & cert. ef. 11-3-06; SPA 1-2007, f. & cert. ef. 2-1-07; SPA 1-2011, f. 1-28-11, cert. ef. 2-1-11; SPA 2-2011, f. & cert. ef. 10-10-11; SPA 2-2012, f. & cert. ef. 12-14-12; SPA 1-2013, f. 4-1-13, cert. ef. 5-1-13; SPA 3-2013(Temp), f. 6-28-13, cert. ef. 7-1-13 thru 12-28-13

335-060-0010
Fees

In accordance with the provisions of ORS 681.340 and 681.360, the following fees, where applicable, are payable to the Board by check, money order, or electronic payment if available:

(1) All Applicants or Licensees:

(a) Application fee shall be $75, non-refundable.

(b) Delinquent fee shall be $100.

(c) A delinquent fee will be charged for each or all of the following, as applicable:

(A) Renewal applications postmarked or submitted electronically after December 31st of odd-numbered years;

(B) Renewal applications postmarked by December 31st of odd numbered years which are incomplete or otherwise unable to be processed;

(C) Conditional license renewals or conditional license upgrade applications postmarked less than 30 days prior to the expiration date of the conditional license;

(D) Temporary license renewal or upgrade applications postmarked or submitted electronically later than the deadlines specified in OAR 335-085-0010.

(d) A delinquent fee may be charged for each or all of the following, as applicable:

(A) Failure to respond to audit by the prescribed deadline;

(B) Audit responses postmarked by the deadline which are incomplete or otherwise unable to be processed;

(C) Failure to complete all required hours of professional development prior to January 1st of even-numbered years;

(D) Failure to update contact information or provide supervisory changes within 30 days of the change.

(E) Failure to report all required hours of speech-language pathology assistant supervision upon audit.

(e) The Board may provide for waiver of the license or certificate fee where the license or certificate is issued less than 45 days before the date on which it will expire.

(f) Fee for Oregon State Police to complete fingerprint-based criminal background check shall be $44.50.

(2) Speech-Language Pathologists and Audiologists:

(a) Biennial license fee and renewal thereof shall be $210.

(b) Biennial inactive license fee and renewal thereof shall be $50.

(c) Conditional license fee and renewal thereof shall be $50.

(d) Temporary license fee shall be $100.

(e) Limited term license fee shall be $100.

(3) Speech-Language Pathology Assistants:

(a) Biennial certificate fee and renewal thereof shall be $65.

(b) Biennial inactive certificate fee and renewal thereof shall be $20.

(c) Temporary license fee shall be $30.

(d) Limited term license fee shall be $30.

Stat. Auth.: ORS 681.340, 681.360, 681.420 & 681.460
Stats. Implemented: ORS 681.340(1), 681.360(2)(b) & 681.360(3)(b)
Hist.: SPA 2-1993(Temp), f. 12-8-93, cert. ef. 12-10-93; SPA 1-1994, f. & cert. ef. 6-10-94; SPA 1-2001, f. & cert. ef. 3-12-01; SPA 1-2002(Temp), f. 11-8-02, cert. ef. 12-1-02 thru 5-1-03; SPA 1-2003, f. & cert. ef. 5-7-03; SPA 1-2005, f. & cert. ef. 9-13-05; SPA 3-2008, f. & cert. ef. 4-10-08; SPA 1-2009, f. 6-9-09, cert. ef. 7-1-09; SPA 1-2010(Temp), f. & cert. ef. 8-11-10 thru 2-4-11; SPA 1-2011, f. 1-28-11, cert. ef. 2-1-11; SPA 3-2011(Temp), f. 10-10-11, cert. ef. 10-11-11 thru 4-4-12; SPA 1-2012, f. & cert. ef. 2-23-12; SPA 1-2013, f. 4-1-13, cert. ef. 5-1-13; SPA 2-2013(Temp), f. & cert. ef. 5-17-13 thru 11-13-13; SPA 3-2013(Temp), f. 6-28-13, cert. ef. 7-1-13 thru 12-28-13

335-085-0010
Qualifications and Procedures for Temporary Licenses

(1) A Limited Term License is a temporary license issued to a speech-language pathologist or audiologist applicant and a Limited Term Certificate is a certificate issued to a speech-language pathology assistant applicant whose application for regular licensure is submitted after May 1st of each odd-numbered year. Applicants for a Conditional License in speech-language pathology are not eligible to obtain limited term licenses.

(a) Limited Term Licenses and Certificates expire at the same time as regular licenses, January 30th of even-numbered years.

(b) Limited Term License or Certificate holders must comply with all Board rules and policies related to applications for license renewal, which must be submitted electronically no later than 11:59 p.m. on December 31st of odd-numbered years. Upon meeting all requirements for license renewal, holders of Limited Term Licenses and Certificates may be issued regular licenses of the same type.

(2) A Temporary Conditional License or a Temporary License may be issued for up to 90 days to a speech-language pathologist or audiologist applicant who meets all other requirements for licensure but whose graduate degree will not be conferred for more than 30 days after completion of all degree requirements, as provided in OAR 335-060-0005(3)(b).

(a) A temporary license issued under this rule is not renewable.

(b) The official transcript must be submitted to the Board office as soon as possible after the degree is conferred, but in no case later than 60 days following issuance of the temporary license. When all licensure requirements are met, the temporary license holder may be issued a regular license of the same type.

Stat. Auth.: ORS 681
Stats. Implemented: ORS 681.285 & 681.340
Hist.: ; SPA 3-2013(Temp), f. 6-28-13, cert. ef. 7-1-13 thru 12-28-13

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Board of Parole and Post-Prison Supervision
Chapter 255

Rule Caption: Amends rules and exhibits governing procedures for predatory sex offender designation.
Adm. Order No.: PAR 4-2013
Filed with Sec. of State: 6-25-2013
Certified to be Effective: 6-25-13
Notice Publication Date: 6-1-2013
Rules Amended: 255-060-0011, 255-060-0016
Subject: Update the administrative rules relating to predatory sex offender designation to specify that the Board shall use the Static-99R (Exhibit Q-l), which has been approved by the Department of Corrections as required by ORS 181.585(2). Improve readability of rule and remove grammatical and other non-substantive errors.
Rules Coordinator: Shawna Harnden—(503) 945-0913

255-060-0011
Procedures for Predatory Sex Offender Designation for Offenders on Parole and Post-Prison Supervision

(1) For purposes of this rule, a predatory sex offender is defined as a person who exhibits characteristics showing a tendency to victimize or injure others and has been convicted of one or more of the following offenses: Rape in any degree, Sodomy in any degree, Unlawful Sexual Penetration in any degree or Sexual Abuse in any degree, or has been convicted of attempting to commit one or has been found guilty except for insanity of one of these crimes. In determining whether an inmate or offender is a predatory sex offender under this rule, the Board shall use the Static-99R (Exhibit Q-l) and definitions (Exhibit Q-2), which have been approved by the Department of Corrections as required by ORS 181.585(2). The Board may also consider any other evidence that the offender exhibits characteristics showing a tendency to victimize or injure others.

(b) All exhibits referenced in this rule are filed with the rule and are available at the Secretary of State's office, the Board's website, or on request from the Board.

(2) Predatory sex offender designations made by the Board for inmates or offenders released from a Department of Corrections institution before November 14, 2012, are not included in this rule. Those designations are governed by the rules in effect when the designation was made.

(3) Subject to the procedures set forth in this rule, the Board will make a finding that an offender is a candidate for predatory sex offender designation, if the offender scores six or more points on the Static-99R and has been convicted of a qualifying offense or has been found guilty except for insanity of a qualifying offense.

(4) Offenders who score six or more points on the Static-99R, and have been identified as a candidate for predatory designation, must be told. They must be provided with a copy of the Static-99R, the Notice of Rights (Exhibit PSO-5) and the Notice of Rights to File Written Objections form (Exhibit Q-3).

(a) The offender should submit any Written Objections (Exhibit Q-4) to the Static-99R score within three business days after signing the Notice of Rights (Exhibit Q-3).

(b) Unless the offender waives the right to submit Written Objections, no sooner than three days after providing the Notice of Rights, the supervising officer will forward the Static-99R, Notice of Rights and Written Objections, if submitted, to the Board. The supervising officer must also include a written report explaining why the offender should be considered for predatory designation. Other materials that support the offender's Static-99R score shall be included.

(c) Upon receipt of the required documents, the Board will review them to verify the accuracy of the score, obtain supporting documentation if necessary, and determine if there is sufficient information to conduct an evidentiary hearing for purposes of determining whether the offender should be designated a predatory sex offender. The Board will prepare a file memo that verifies the index offense, qualifying conviction, and each point awarded on the Static-99R. The file memo will address offender's written objections. If the Board determines there is sufficient information in the documents, it will forward them to its hearings officer, who will schedule an evidentiary hearing.

(5)(a) The supervising officer or the Board's hearings officer will provide the offender with: the documentation submitted by the supervising officer; the Static-99R; the memo prepared by the Board; and the Notice of Rights regarding an evidentiary hearing (Exhibit PSO-5).

(b) Unless the offender waives their right to an evidentiary hearing, a hearing will be held. Refusal to participate in the notice of rights process will be considered a waiver.

(c) The sole purpose of the evidentiary hearing will be to determine whether the offender exhibits characteristics showing a tendency to victimize or injure others.

(6)(a) At the evidentiary hearing, the hearings officer will consider the written report submitted by the supervising officer, the Static-99R, and any additional evidence supporting the Static-99R score or otherwise indicating that the offender exhibits characteristics showing a tendency to victimize or injure others.

(b) The offender may present evidence rebutting claims made in the supervising officer's written report, challenge the Static-99R score, or rebut other evidence that the offender exhibits characteristics showing a tendency to victimize or injure others.

(c) After consideration of all the evidence presented at the evidentiary hearing, the hearings officer will submit a report to the Board with a recommendation as to whether the offender is exhibiting characteristics showing a tendency to victimize or injure others.

(7)(a) Upon receipt of the report and recommendation from the Board's hearings officer, the Board will review the report and recommendation and determine whether the offender exhibits characteristics showing a tendency to victimize or injure others and is, therefore, a predatory sex offender.

(b) A finding that an offender is a predatory sex offender must be made by at least two Board members.

(c) The Board will issue an order of supervision containing the predatory designation. Upon receipt of the order, the offender's supervising officer must present it to the offender and document that the offender received the order.

(8) Pursuant to ORS 181.586, the community corrections agency supervising an offender found to be a predatory sex offender shall notify anyone whom the agency determines is appropriate that the person is a predatory sex offender. The agency shall make this determination as required by ORS 181.586.

[ED. NOTE: Exhibits referenced are available from the agency.]

Stat. Auth.: ORS 144.050, 144.140, 181.585 & 181.586

Stats. Implemented:

Hist.: PAR 4-2000, f. & cert. ef. 2-15-00; PAR 1-2002(Temp), f. & cert. ef. 1-15-02 thru 7-13-02; PAR 4-2002, f. & cert. ef. 3-12-02; PAR 5-2003, f. & cert. ef. 10-10-03; PAR 2-2004(Temp), f. & cert. ef. 1-41-04 thru 7-11-04; PAR 7-2004, f. & cert. ef. 6-14-04; PAR 1-2006(Temp), f. & cert. ef. 3-20-06 thru 9-15-06; PAR 5-2006, f. & cert. ef. 6-14-06; PAR 6-2006(Temp), f. 6-14-06 cert. ef. 6-15-06 thru 12-11-06; PAR 9-2006, f. & cert. ef. 10-9-06; PAR 1-2008, f. & cert. ef. 1-11-08; PAR 3-2008, f. & cert. ef. 9-12-08; PAR 5-2012(Temp), f. & cert. ef. 11-15-12 thru 5-13-13; Administrative correction, 5-22-13; PAR 4-2013, f. & cert. ef. 6-25-13

255-060-0016

Procedures for Predatory Sex Offender Designation for Inmates

(1) For purposes of this rule, a predatory sex offender is defined as a person who exhibits characteristics showing a tendency to victimize or injure others and has been convicted of one or more of the following offenses: Rape in any degree, Sodomy in any degree, Unlawful Sexual Penetration in any degree or Sexual Abuse in any degree, or has been convicted of attempting to commit one or has been found guilty except for insanity or one of these crimes. In determining whether an inmate or offender is a predatory sex offender under this rule, the Board shall use the Static-99R (Exhibit Q-l) and definitions (Exhibit Q-2), which have been approved by the Department of Corrections as required by ORS 181.585(2). The Board may also consider evidence that the inmate exhibits characteristics showing a tendency to victimize or injure others.

(b) All exhibits referenced in this rule are filed with the rule and are available at the Secretary of State's office, the Board's website, or on request from the Board.

(2) Predatory sex offender designations made by the board for inmates released from a Department of Corrections institution before November 14, 2012, are not included in this rule. Those designations are governed by the rules in effect when the designation was made or when the inmate was released from custody.

(3) Subject to the procedures set forth in this rule, the Board will make a finding that an inmate is a candidate for predatory sex offender designation, if the inmate scores six or more points on the Static-99R and has been convicted of a qualifying offense or has been found guilty except for insanity of a qualifying offense.

(4) Inmates who score six or more points on the Static-99R, and have been identified as a candidate for predatory designation, must be told. They must be provided with a copy of the completed Static-99R, the Notice of Rights (Exhibit PSO-5) and the Notice of Rights to File Written Objections form (Exhibit Q-3).

(a) The inmate should submit any Written Objections (Exhibit Q-4) to the Static-99R score within three business days after signing the Notice of Rights.

(b) Unless the inmate waives the right to submit Written Objections, no sooner than three days after providing the Notice of Rights, the counselor will forward the Static-99R, Notice of Rights and Written Objections, if submitted, to the Board. Other available materials that support the inmate's Static-99R score shall be included.

(c) Upon receipt of the required documents, the Board will review them to verify the accuracy of the score and obtain supporting documentation if necessary to determine if there is sufficient information to conduct an evidentiary hearing for purposes of determining whether the inmate should be designated a predatory sex offender. The Board will prepare a file memo that verifies the index offense, qualifying conviction, and each point awarded on the Static-99R. The file memo will address inmate's written objections. If the Board determines there is sufficient information in the documents, the inmate will be scheduled for a sex offender evaluation.

(d) Refusal to participate in a sex offender evaluation will not exclude inmate from predatory consideration.

(e) Should the sex offender evaluation determine that the inmate is exhibiting characteristics showing a tendency to victimize or injure others the inmate shall be provided with a copy of the sex offender evaluation and the Board's memo verifying the Static-99R points. Unless inmate waives the right to an evidentiary hearing, a hearing will be held. Refusal to participate in the notice of rights process will be considered a waiver.

(f) The sole purpose of the evidentiary hearing is to determine if the inmate exhibits characteristics showing a tendency to victimize or injure others.

(5)(a) At the evidentiary hearing, the Board will consider the written report submitted by the sex offender evaluator, the Static-99R, and any additional evidence supporting the Static-99R score or otherwise indicating that the inmate exhibits characteristics showing a tendency to victimize or injure others.

(b) The inmate may present evidence rebutting claims made in the sex offender evaluator's written report, challenge the Static-99R score, or rebut other evidence that the inmate exhibits characteristics showing a tendency to victimize or injure others.

(c) After consideration of all the evidence presented at the hearing, the Board will make a determination as to whether the inmate should be designated as a predatory sex offender.

(6) A finding that an inmate is a predatory sex offender must be made by at least two Board members.

(7) Pursuant to ORS 181.586, the community corrections agency supervising an inmate or offender found to be a predatory sex offender shall notify anyone whom the agency determines is appropriate that the person is a predatory sex offender. The agency shall make this determination as required by ORS 181.586.

[ED. NOTE: Exhibits referenced are available from the agency.]

Stat. Auth.: ORS 144.050, 144.140, 181.585, 181.586

Other Auth. V.L.Y v. Board of Parole & Post-Prison Supervision, 338 Or 44(2005)

Hist.: PAR 7-2006(Temp), f. & cert. ef. 8-7-2006 thru 2-2-07; Suspended by PAR 8-2006(Temp), f. & cert. ef. 8-30-06 thru 2-2-07; PAR 10-2006, f. & cert. ef. 10-30-06; PAR

4-2007, f. & cert. ef 7-17-07; PAR 3-2008, f. & cert. ef. 9-12-08; PAR 5-2012(Temp), f. & cert. ef. 11-15-12 thru 5-13-13; Administrative correction, 5-22-13; PAR 4-2013, f. & cert. ef. 6-25-13

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Board of Pharmacy
Chapter 855

Rule Caption: Implements temporary revenue surplus reductions pursuant to ORS 291.055(3) for certain licensing fees.
Adm. Order No.: BP 3-2013(Temp)
Filed with Sec. of State: 6-27-2013
Certified to be Effective: 7-1-13 thru 12-28-13
Notice Publication Date:
Rules Amended: 855-110-0005, 855-110-0007, 855-110-0010
Subject: Implements temporary revenue surplus reductions pursuant to ORS 291.055(3) for certain licensing fees as approved in the Board's 2013-15 Legislatively Approved Budget. Please Note: this in addition to the Pharmacist fee that was reduced in April of this year. Copies of the full text of these rules can be obtained on the Board's website at www.pharmacy.state.or.us, or by calling the Board office (971) 673-0001.
Rules Coordinator: Karen MacLean—(971) 673-0001

855-110-0005
Licensing Fees

(1) Pharmacist license examination (NAPLEX) and re-examination fee — $50.

(2) Pharmacist jurisprudence (MPJE) re-examination fee — $25.

(3) Pharmacist licensing by reciprocity fee — $200*. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)).

(4) Pharmacist licensing by score transfer fee — $300.

(5) Intern license fee. Expires November 30 every two years — $50.

(6) Pharmacist:

(a) License fee. Expires June 30 annually — $120*. Delinquent renewal fee, (postmarked after May 31) — $50. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)).

(b) Electronic Prescription Monitoring Fund fee. Due by June 30 annually — $25. (This is a mandatory fee, required by ORS 431.972 that must be paid with the pharmacist license renewal fee).

(c) Workforce Data Collection fee. Due by June 30 biennially — $5. (This is a mandatory fee, it may be charged annually at $2.50 per year as required by OAR 409-026-0130 that must be paid with the pharmacist license renewal fee.

(7) Certification of approved provider of continuing education course fee, none at this time.

(8)(a) Pharmacy Technician license fee. (This is a one year non-renewable license unless under the age of 19) — $50.

(b) Under 19 years of age expires September 30 annually — $50. Delinquent renewal fee, (postmarked after August 31) — $20.

(9) Certified Pharmacy Technician:

(a) License fee. Expires September 30 annually — $50. Delinquent renewal fee, (postmarked after August 31) — $20.

(b) Workforce Data Collection fee. Due by June 30 biennially — $5. (This is a mandatory fee, it may be charged annually at $2.50 per year as required by OAR 409-026-0130 that must be paid with the Certified Pharmacy Technician license renewal fee.

Stat. Auth.: ORS 689.205 & 291.055
Stats. Implemented: ORS 689.135, 431.972 & 676.410
Hist.: 1PB 2-1979(Temp), f. & ef. 10-3-79; 1PB 2-1980, f. &ef. 4-3-80; 1PB 3-1980, f. 5-3-80, ef. 5-3-80 & 7-1-80; 1PB 2-1982, f. 3-8-82, ef. 4-1-82; 1PB 1-1984, f. & ef. 2-16-84; 1PB 3-1985, f. & ef. 12-2-85; PB 3-1988, f. & cert. ef. 5-23-88; PB 7-1989, f. & cert. ef. 5-1-89; PB 15-1989, f. & cert. ef. 12-26-89; PB 10-1990, f. & cert. ef. 12-5-90; PB 3-1991, f. & cert. ef. 9-19-91; PB 1-1992, f. & cert. ef. 1-31-92 (and corrected 2-7-92); PB 4-1992, f. & cert. ef. 8-25-92; PB 1-1994, f. & cert. ef. 2-2-94; PB 1-1996, f. & cert. ef. 4-5-96; PB 2-1997(Temp), f. 10-2-97, cert. ef. 10-4-97; BP 2-1998, f. & cert. ef. 3-23-98; BP 1-2001, f. & cert. ef. 3-5-01; BP 2-2001(Temp), f. & cert. ef. 7-26-01 thru 1-22-02; BP 1-2002, f. & cert. ef. 1-8-02; BP 1-2003, f. & cert. ef. 1-14-03; BP 1-2006, f. & cert. ef. 6-9-06; BP 5-2006(Temp), f. & cert. ef. 8-25-06 thru 1-20-07; BP 9-2006, f. & cert. ef. 12-19-06; BP 5-2009, f. & cert. ef. 12-24-09; BP 5-2010(Temp), f. 5-3-10, cert. ef. 5-4-10 thru 10-30-10; BP 6-2010, f. & cert. ef. 6-29-10; BP 5-2011(Temp), f. 6-24-11, cert. ef. 7-1-11 thru 12-27-11; BP 8-2011, f. & cert. ef. 12-15-11; BP 2-2013(Temp), f. 4-4-13, cert. ef. 4-5-13 thru 9-28-13; BP 3-2013(Temp), f. 6-27-13, cert. ef. 7-1-13 thru 12-28-13

855-110-0007
Fees for Registration, Renewal, and Reinspection of Drug Outlets

(1) County Health Clinic (including family planning clinics). Expires March 31 annually — $75*. Delinquent renewal fee (postmarked after February 28) — $25. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)).

(2) Drug Distribution Agent. Expires September 30 annually — $400. Delinquent renewal fee (postmarked after August 31) — $100.

(3) Drug Room (including correctional facility). Expires March 31 annually — $75*. Delinquent renewal fee (postmarked after February 28) — $75. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)).

(4) Manufacturer. Expires September 30 annually — $400. Delinquent renewal fee (postmarked after August 31) — $100.

(5) Medical Device, Equipment & Gas Class C. Expires January 31 annually — $50. Delinquent renewal fee (postmarked after December 31) — $25.

(6) Nonprescription Class A. Expires January 31 annually — $50. Delinquent renewal fee (postmarked after December 31) — $25.

(7) Nonprescription Class B. Expires January 31 annually — $50. Delinquent renewal fee (postmarked after December 31) — $25.

(8) Nonprescription Class D. Expires January 31 annually — $100. Delinquent renewal fee (postmarked after December 31) — $25.

(9) Prophylactic and/or Contraceptive Wholesaler and/or Manufacturer — $50*. Expires December 31 annually. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)).

(10) Re-inspection fee — $100. Applies to any re-inspection of a drug outlet occasioned to verify corrections of violations found in an initial inspection.

(11) Retail or Institutional Drug Outlet. Expires March 31 annually — $175*. Delinquent renewal fee (postmarked after February 28) — $75. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)).

(12) Wholesaler Class I, Expires September 30 annually — $400. Delinquent renewal fee (postmarked after August 31) — $100.

(13) Wholesaler Class II. Expires September 30 annually — $400. Delinquent renewal fee (postmarked after August 31) — $100.

(14) Remote Dispensing Machine/Facility. Expires March 31 annually — $100. Due by February 28 annually.

(15) Charitable Pharmacy. Expires March 31 annually — $75. Delinquent renewal fee (postmarked after February 28) — $25.

(16) Home Dialysis. Expires March 31 annually — $175*. Delinquent renewal fee (postmarked after February 28) — $75. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)).

(17) Supervising Physician Dispensing Outlet. Expires March 31 annually — $300. Delinquent renewal fee (postmarked after February 28) — $75.

Stat. Auth.: ORS 689.205 & 291.055
Stats. Implemented: ORS 689.135, 689.774 & 2012 OL Ch. 34
Hist.: PB 1-1996, f. & cert. ef. 4-5-96; PB 1-1997, f. & cert. ef. 9-22-97; BP 3-1998, f. & cert. ef. 3-23-98; BP 2-2001(Temp), f. & cert. ef. 7-26-01 thru 1-22-02; BP 1-2002, f. & cert. ef. 1-8-02; BP 4-2002, f. 6-27-02, cert. ef. 7-1-02; BP 2-2005, f. 2-14-05, cert. ef. 3-1-05; BP 2-2009(Temp), f. 6-22-09, cert. ef. 6-26-09 thru 12-23-09; BP 5-2009, f. & cert. ef. 12-24-09; BP 6-2010, f. & cert. ef. 6-29-10; BP 5-2011(Temp), f. 6-24-11, cert. ef. 7-1-11 thru 12-27-11; BP 8-2011, f. & cert. ef. 12-15-11; BP 5-2012(Temp), f. & cert. ef. 6-19-12 thru 12-16-12; BP 6-2012, f. & cert. ef. 12-13-12; BP 3-2013(Temp), f. 6-27-13, cert. ef. 7-1-13 thru 12-28-13

855-110-0010
Fees for Registration for Controlled Substances under ORS 475.095

(1) Animal Euthanasia controlled substance registration fee — $50 annually.

(2) Drug Distribution Agent controlled substance registration fee — $50* annually. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)).

(3) Drug Room (including correctional facility) controlled substance registration fee — $50* annually. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)).

(4) Manufacturer controlled substance registration fee — $50* annually. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)).

(5) Retail or Institutional Drug Outlet controlled substance registration fee — $50* annually. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)).

(6) Schedule II Precursor registration fee — $50* annually. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)).

(7) Wholesaler controlled substance registration fee — $50* annually. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)).

(8) Remote Dispensing Facility controlled substance registration fee — $50* annually. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)).

Stat. Auth.: ORS 689.205 & 291.055
Stats. Implemented: ORS 689.135
Hist.: 1PB 2-1979(Temp), f. & ef. 10-3-79; 1PB 2-1980, f. & ef. 4-3-80; 1PB 6-1982, f. & ef. 8-6-82; 1PB 2-1984, f. & ef. 3-7-84; PB 15-1989, f. & cert. ef. 12-26-89; PB 10-1990, f.

& cert. ef. 12-5-90; PB 3-1991, f. & cert. ef. 9-19-91; PB 1-1996, f. & cert. ef. 4-5-96; BP 2-2005, f. 2-14-05, cert. ef. 3-1-05; BP 2-2009(Temp), f. 6-22-09, cert. ef. 6-26-09 thru 12-23-09; BP 5-2009, f. & cert. ef. 12-24-09; BP 5-2011(Temp), f. 6-24-11, cert. ef. 7-1-11 thru 12-27-11; BP 8-2011, f. & cert. ef. 12-15-11; BP 3-2013(Temp), f. 6-27-13, cert. ef. 7-1-13 thru 12-28-13

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Rule Caption: Implements temporary revenue surplus reductions pursuant to ORS 291.055(3) for certain licensing fees.
Adm. Order No.: BP 4-2013(Temp)
Filed with Sec. of State: 7-9-2013
Certified to be Effective: 7-9-13 thru 1-5-14
Notice Publication Date:
Rules Amended: 855-110-0005, 855-110-0007, 855-110-0010
Subject: Implements temporary revenue surplus reductions pursuant to ORS 291.055(3) for certain licensing fees as approved in the Board's 2013–15 Legislatively Approved Budget. Please note: this is in addition to the Pharmacist fee that was reduced in April of this year.

Rules are being refiled due to a filing error. These rules are effective retroactive on

July 1, 2013. Copies of the full text of these rules can be obtained on the Board's website at www.pharmacy.state.or.us, or by calling the Board office

(971) 673-0001.
Rules Coordinator: Karen MacLean—(971) 673-0001

855-110-0005
Licensing Fees

(1) Pharmacist license examination (NAPLEX) and re-examination fee — $50.

(2) Pharmacist jurisprudence (MPJE) re-examination fee — $25.

(3) Pharmacist licensing by reciprocity fee — $200*. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)). Fee reduction shall be effective retroactive to July 1, 2013.

(4) Pharmacist licensing by score transfer fee — $300.

(5) Intern license fee. Expires November 30 every two years — $50.

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(a) License fee. Expires June 30 annually — $120*. Delinquent renewal fee, (postmarked after May 31) — $50. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)).

(b) Electronic Prescription Monitoring Fund fee. Due by June 30 annually — $25. (This is a mandatory fee, required by ORS 431.972 that must be paid with the pharmacist license renewal fee).

(c) Workforce Data Collection fee. Due by June 30 biennially — $5. (This is a mandatory fee, it may be charged annually at $2.50 per year as required by OAR 409-026-0130 that must be paid with the pharmacist license renewal fee.

(7) Certification of approved provider of continuing education course fee, none at this time.

(8)(a) Pharmacy Technician license fee. (This is a one year nonrenewable license unless under the age of 19) — $50.

(b) Under 19 years of age expires September 30 annually — $50. Delinquent renewal fee, (postmarked after August 31) — $20.

(9) Certified Pharmacy Technician:

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(b) Workforce Data Collection fee. Due by June 30 biennially — $5. (This is a mandatory fee, it may be charged annually at $2.50 per year as required by OAR 409-026-0130 that must be paid with the Certified Pharmacy Technician license renewal fee.

Stat. Auth.: ORS 689.205 & 291.055
Stats. Implemented: ORS 689.135, 431.972 & 676.410
Hist.: 1PB 2-1979(Temp), f. & ef. 10-3-79; 1PB 2-1980, f. &ef. 4-3-80; 1PB 3-1980, f. 5-3-80, ef. 5-3-80 & 7-1-80; 1PB 2-1982, f. 3-8-82, ef. 4-1-82; 1PB 1-1984, f. & ef. 2-16-84; 1PB 3-1985, f. & ef. 12-2-85; PB 3-1988, f. & cert. ef. 5-23-88; PB 7-1989, f. & cert. ef. 5-1-89; PB 15-1989, f. & cert. ef. 12-26-89; PB 10-1990, f. & cert. ef. 12-5-90; PB 3-1991, f. & cert. ef. 9-19-91; PB 1-1992, f. & cert. ef. 1-31-92 (and corrected 2-7-92); PB 4-1992, f. & cert. ef. 8-25-92; PB 1-1994, f. & cert. ef. 2-2-94; PB 1-1996, f. & cert. ef. 4-5-96; PB 2-1997(Temp), f. 10-2-97, cert. ef. 10-4-97; BP 2-1998, f. & cert. ef. 3-23-98; BP 1-2001, f. & cert. ef. 3-5-01; BP 2-2001(Temp), f. & cert. ef. 7-26-01 thru 1-22-02; BP 1-2002, f. & cert. ef. 1-8-02; BP 1-2003, f. & cert. ef. 1-14-03; BP 1-2006, f. & cert. ef. 6-9-06; BP 5-2006(Temp), f. & cert. ef. 8-25-06 thru 1-20-07; BP 9-2006, f. & cert. ef. 12-19-06; BP 5-2009, f. & cert. ef. 12-24-09; BP 5-2010(Temp), f. 5-3-10, cert. ef. 5-4-10 thru 10-30-10; BP 6-2010, f. & cert. ef. 6-29-10; BP 5-2011(Temp), f. 6-24-11, cert. ef. 7-1-11 thru 12-27-11; BP 8-2011, f. & cert. ef. 12-15-11; BP 2-2013(Temp), f. 4-4-13, cert. ef. 4-5-13 thru 9-28-13; BP 3-2013(Temp), f. 6-27-13, cert. ef. 7-1-13 thru 12-28-13; BP 4-2013(Temp), f. & cert. ef. 7-9-13 thru 1-5-13

855-110-0007
Fees for Registration, Renewal, and Reinspection of Drug Outlets

(1) County Health Clinic (including family planning clinics). Expires March 31 annually — $75*. Delinquent renewal fee (postmarked after February 28) — $25. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)). Fee reduction shall be effective retroactive to July 1, 2013.

(2) Drug Distribution Agent. Expires September 30 annually — $400. Delinquent renewal fee (postmarked after August 31) — $100.

(3) Drug Room (including correctional facility). Expires March 31 annually — $75*. Delinquent renewal fee (postmarked after February 28) — $75. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)). Fee reduction shall be effective retroactive to July 1, 2013.

(4) Manufacturer. Expires September 30 annually — $400. Delinquent renewal fee (postmarked after August 31) — $100.

(5) Medical Device, Equipment & Gas Class C. Expires January 31 annually — $50. Delinquent renewal fee (postmarked after December 31) — $25.

(6) Nonprescription Class A. Expires January 31 annually — $50. Delinquent renewal fee (postmarked after December 31) — $25.

(7) Nonprescription Class B. Expires January 31 annually — $50. Delinquent renewal fee (postmarked after December 31) — $25.

(8) Nonprescription Class D. Expires January 31 annually — $100. Delinquent renewal fee (postmarked after December 31) — $25.

(9) Prophylactic and/or Contraceptive Wholesaler and/or Manufacturer — $50*. Expires December 31 annually. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)). Fee reduction shall be effective retroactive to July 1, 2013.

(10) Re-inspection fee — $100. Applies to any re-inspection of a drug outlet occasioned to verify corrections of violations found in an initial inspection.

(11) Retail or Institutional Drug Outlet. Expires March 31 annually — $175*. Delinquent renewal fee (postmarked after February 28) — $75. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)). Fee reduction shall be effective retroactive to July 1, 2013.

(12) Wholesaler Class I, Expires September 30 annually — $400. Delinquent renewal fee (postmarked after August 31) — $100.

(13) Wholesaler Class II. Expires September 30 annually — $400. Delinquent renewal fee (postmarked after August 31) — $100.

(14) Remote Dispensing Machine/Facility. Expires March 31 annually — $100. Due by February 28 annually.

(15) Charitable Pharmacy. Expires March 31 annually — $75. Delinquent renewal fee (postmarked after February 28) — $25.

(16) Home Dialysis. Expires March 31 annually — $175*. Delinquent renewal fee (postmarked after February 28) — $75. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)). Fee reduction shall be effective retroactive to July 1, 2013.

(17) Supervising Physician Dispensing Outlet. Expires March 31 annually — $300. Delinquent renewal fee (postmarked after February 28) — $75.

Stat. Auth.: ORS 689.205 & 291.055
Stats. Implemented: ORS 689.135, 689.774 & 2012 OL Ch. 34
Hist.: PB 1-1996, f. & cert. ef. 4-5-96; PB 1-1997, f. & cert. ef. 9-22-97; BP 3-1998, f. & cert. ef. 3-23-98; BP 2-2001(Temp), f. & cert. ef. 7-26-01 thru 1-22-02; BP 1-2002, f. & cert. ef. 1-8-02; BP 4-2002, f. 6-27-02, cert. ef. 7-1-02; BP 2-2005, f. 2-14-05, cert. ef. 3-1-05; BP 2-2009(Temp), f. 6-22-09, cert. ef. 6-26-09 thru 12-23-09; BP 5-2009, f. & cert. ef. 12-24-09; BP 6-2010, f. & cert. ef. 6-29-10; BP 5-2011(Temp), f. 6-24-11, cert. ef. 7-1-11 thru 12-27-11; BP 8-2011, f. & cert. ef. 12-15-11; BP 5-2012(Temp), f. & cert. ef. 6-19-12 thru 12-16-12; BP 6-2012, f. & cert. ef. 12-13-12; BP 3-2013(Temp), f. 6-27-13, cert. ef. 7-1-13 thru 12-28-13; BP 4-2013(Temp), f. & cert. ef. 7-9-13 thru 1-5-13

855-110-0010
Fees for Registration for Controlled Substances under ORS 475.095

(1) Animal Euthanasia controlled substance registration fee — $50 annually.

(2) Drug Distribution Agent controlled substance registration fee — $50* annually. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)). Fee reduction shall be effective retroactive to July 1, 2013.

(3) Drug Room (including correctional facility) controlled substance registration fee — $50* annually. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)). Fee reduction shall be effective retroactive to July 1, 2013.

(4) Manufacturer controlled substance registration fee — $50* annually. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)). Fee reduction shall be effective retroactive to July 1, 2013.

(5) Retail or Institutional Drug Outlet controlled substance registration fee — $50* annually. (*Temporary revenue surplus fee reduction pur-

suant to ORS 291.055(3)). Fee reduction shall be effective retroactive to July 1, 2013.

(6) Schedule II Precursor registration fee — $50* annually. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)). Fee reduction shall be effective retroactive to July 1, 2013.

(7) Wholesaler controlled substance registration fee — $50* annually. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)). Fee reduction shall be effective retroactive to July 1, 2013.

(8) Remote Dispensing Facility controlled substance registration fee — $50* annually. (*Temporary revenue surplus fee reduction pursuant to ORS 291.055(3)). Fee reduction shall be effective retroactive to July 1, 2013.

Stat. Auth.: ORS 689.205 & 291.055
Stats. Implemented: ORS 689.135
Hist.: 1PB 2-1979(Temp), f. & ef. 10-3-79; 1PB 2-1980, f. & ef. 4-3-80; 1PB 6-1982, f. & ef. 8-6-82; 1PB 2-1984, f. & ef. 3-7-84; PB 15-1989, f. & cert. ef. 12-26-89; PB 10-1990, f. & cert. ef. 12-5-90; PB 3-1991, f. & cert. ef. 9-19-91; PB 1-1996, f. & cert. ef. 4-5-96; BP 2-2005, f. 2-14-05, cert. ef. 3-1-05; BP 2-2009(Temp), f. 6-22-09, cert. ef. 6-26-09 thru 12-23-09; BP 5-2009, f. & cert. ef. 12-24-09; BP 5-2011(Temp), f. 6-24-11, cert. ef. 7-1-11 thru 12-27-11; BP 8-2011, f. & cert. ef. 12-15-11; BP 3-2013(Temp), f. 6-27-13, cert. ef. 7-1-13 thru 12-28-13; BP 4-2013(Temp), f. & cert. ef. 7-9-13 thru 1-5-13

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Board of Psychologist Examiners
Chapter 858

Rule Caption: Modifies definition of "in-residence" for the clinical psychology educational requirements.
Adm. Order No.: BPE 2-2013
Filed with Sec. of State: 7-15-2013
Certified to be Effective: 7-15-13
Notice Publication Date: 5-1-2013
Rules Amended: 858-010-0010
Subject: The proposed amendment applies to applicants who possess a doctoral degree from a regionally accredited, provincially chartered, or foreign program and can verify that they enrolled in their program prior to August 12, 2011. The change will allow such applicants to apply the "old rule" definition of one continuous year "in-residence" at the institution from which the degree is granted. This provision will be effective through August 12, 2015.
Rules Coordinator: LaReé Felton—(503) 373-1196

858-010-0010
Education Requirements — Clinical Psychology

To meet the education requirement of ORS 675.030(1), applicants for licensure must:

(1) Possess a doctoral degree in psychology from a program accredited by the American Psychological Association or the Canadian Psychological Association as of the date the degree was awarded; or

(2) Possess a doctoral degree in psychology from:

(a) A program at an institution of higher learning that was accredited by a regional accrediting agency as of the date the degree was awarded;

(b) For Canadian universities, an institution of higher education that is provincially or territorially chartered; or

(c) A foreign program evaluated to be equivalent to American Psychological Association accreditation as of the date the degree was awarded. Evaluation must be completed by a credentialing body recognized by the Board. Submission of proof of foreign degree equivalency and cost of the foreign degree equivalency determination are the responsibility of the applicant.

(3) An applicant who possesses a degree under section (2) must show that his or her doctoral program in psychology meets all of the following requirements:

(a) A minimum of three academic years of full-time graduate study.

(b) A minimum of one continuous year in residence at the institution from which the degree is granted.

(A) One continuous year means two consecutive semesters or three consecutive quarters.

(B) In residence means physical presence, in person, at an educational institution or training facility in a manner that facilitates acculturation into the profession, the full participation and integration of the individual in the educational and training experience, and includes faculty and student interaction.

(C) The doctoral program may include distance education, but a minimum of one continuous year of the program shall be in-residence. Programs that use physical presence, including face-to-face contact for durations of less than one continuous year, (e.g., multiple long weekends and/or summer intensive sessions) or that use video teleconferencing or other electronic means as a substitute for physical presence at the institution in order to meet the residency requirement are deemed not to be acceptable for licensure.

(D) Training models that rely exclusively on physical presence for periods of less than one continuous year (e.g., multiple long weekends and/or summer intensive sessions) or that use video teleconferencing or other electronic means as a substitute for physical presence at the institution do not meet the in residence requirement.

(E) Effective through August 12, 2015, applicants who can verify that they enrolled in their program prior to August 12, 2011 may apply under the "old rule" definition of in-residence. Under this provision, one continuous year means a minimum of 500 hours of student-faculty contact involving face-to-face individual or group educational meetings. Such educational meetings must include both faculty-student and student-student interaction, be conducted by the psychology faculty of the institution at least 90 percent of the time, be documented by the applicant and the institution, and relate substantially to the program components specified. Items such as receptions, meals, group socials and library tours may not count towards the minimum 500 hours of educational meetings. Applicants applying under this provision shall submit full documentation that they have met this requirement, which must include a detailed description of the content of the 500 hours of educational meetings and be verified by the administration of the doctoral program.

(c) The program, wherever it may be administratively housed, must be clearly identified and labeled as a program in psychology. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists.

(d) The psychology program must stand as a recognizable, coherent organizational entity within the institution.

(e) There must be a clear authority and primary responsibility for the core and specialty areas, whether or not the program cuts across administrative lines.

(f) The program must be an integrated, organized sequence of study.

(g) There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities and a psychologist responsible for the program.

(h) The program must have an identifiable body of students who are matriculated in that program for a degree.

(i) The program must include a coordinated, sequential and supervised practicum appropriate to the practice of psychology as described in OAR 858-010-0012.

(j) The program must include a coordinated, sequential and supervised internship, field or laboratory training appropriate to the practice of psychology as described in OAR 858-010-0013.

(k) The curriculum of the program must:

(A) Encompass a minimum of three academic years of full time graduate study, including a minimum of one continuous year in residence at the educational institution granting the doctoral degree;

(B) Require an original dissertation or equivalent that was psychological in nature that meets the requirement for an approved doctoral program; and

(C) Include at least 30 semester hours or 45 quarter hours of credit in graded (not "pass-no pass") courses.

(l) The core program shall include a minimum of three graduate semester hours or 4.5 or more graduate quarter hours (when an academic term is other than a semester, credit hours will be evaluated on the basis of 15 hours of classroom instruction per semester hour) in each of the following substantive content areas:

(A) Scientific and professional ethics and standards;

(B) Research design and methodology;

(C) Statistics;

(D) Psychometric theory;

(E) Biological bases of behavior such as physiological psychology, comparative psychology, neuropsychology, sensation and perception, physical ergonomics, or psychopharmacology;

(F) Cognitive-affective bases of behavior such as learning, thinking, motivation, emotion, memory, cognitive information processing, or social cognition;

(G) Social bases of behavior such as social psychology, group processes, organizational and systems theory; and

(H) Individual differences in behavior such as personality theory, human development, personnel psychology or abnormal psychology.

(m) All professional education programs in psychology must include course requirements in developed practice areas/specialties.

(n) The program must demonstrate that it provides training relevant to the development of competence to practice in a diverse and multicultural society.

(o) Demonstration of competence in clinical psychology shall be met by a minimum of 18 semester hours or 27 quarter hours in the following areas: personality and intellectual assessment, diagnosis, therapeutic intervention, and evaluating the efficacy of intervention.

(p) If the doctoral program does not meet the core and/or clinical coursework requirements of (l) and (o), the applicant for licensure may remedy a deficiency of up to 6 semester hours or 9 quarter hours by completing graduate level coursework in the deficient content area(s) at a regionally accredited institution.

(4) Provide syllabi or other documentation regarding course content upon the Board's request.

Stat. Auth.: ORS 675.030
Stats. Implemented: ORS 675.030(1)(b)(c)
Hist.: PE 6, f. 12-19-73, ef. 1-11-74; PE 1-1992, f. & cert. ef. 1-16-92; PE 3-1992, f. & cert. ef. 7-14-92; PE 1-1996, f. & cert. ef. 6-25-96; PE 1-1997, f. & cert. ef. 6-17-97; BPE 1-2001(Temp), f. & cert. ef. 8-31-01 thru 2-27-02; BPE 2-2002, f. & cert. ef. 2-27-02; BPE 1-2008, f. & cert. ef. 3-26-08; BPE 1-2010, f. & cert. ef. 1-8-10; BPE 2-2010, f. & cert. ef. 9-28-10; BPE 1-2011, f. & cert. ef. 1-25-11; BPE 2-2011, f. & cert. ef. 5-31-11; BPE 3-2011, f. & cert. ef. 9-27-11; BPE 1-2012(Temp), f. & cert. ef. 2-15-12 thru 8-12-12; BPE 2-2012, f. & cert. ef. 6-8-12; BPE 3-2012(Temp), f. & cert. ef. 10-15-12 thru 4-13-13; BPE 1-2013, f. & cert. ef. 2-5-13; BPE 2-2013, f. & cert. ef. 7-15-13

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Department of Administrative Services, Budget and Management Division
Chapter 122

Rule Caption: Establishes expenditure limits allowing agencies without a 2013–15 Legislatively Adopted Budget to continue operating.
Adm. Order No.: BMD 1-2013(Temp)
Filed with Sec. of State: 6-27-2013
Certified to be Effective: 6-27-13 thru 8-15-13
Notice Publication Date:
Rules Adopted: 122-001-0037
Subject: This rule establishes expenditure limits allowing state agencies without a 2013–15 Legislatively Adopted Budget to continue operating after June 30, 2013.
Rules Coordinator: Janet Chambers—(503) 378-5522

122-001-0037
Continuing Resolution for State Agency Expenditure Limitations

(1) A state agency, as defined in Senate Bill 5504 (Oregon Laws 2013), may incur obligations and authorized expenditures to continue operations into the 2013–2015 biennium at:

(a) The agency's 2011–2013 eighth quarter allotment level; or

(b) For the Department of Human Services, the agency's 2011–2013 seventh quarter allotment level; or

(c) For the Oregon Health Authority, the agency's 2011–2013 sixth quarter allotment level; or

(d) A higher or lower level as approved by the Chief Financial Office.

(e) In establishing an alternative expenditure level, the Chief Financial Office shall consider pending legislative budget direction.

(2) Each state agency without a legislatively adopted budget as of June 30, 2013, shall send a signed letter of verification to the Chief Financial Office on or before June 30, 2013, acknowledging:

(a) The agency does not have a legislatively adopted budget as of June 30, 2013;

(b) The continuing resolution ends August 15, 2013 or when an adopted budget is signed by the Governor;

(c) Expenditures will not be authorized above the level established pursuant to section (1) of this rule;

(d) Expenditures incurred under the continuing resolution will be part of the 2013–2015 adopted budget and not permanently charged against 2011–2013 expenditure limitation or appropriation; and

(e) The agency will not begin new programs or hire new staff positions until an adopted budget is signed by the Governor.

(3) Upon receipt of the signed verification letter, the Chief Financial Office shall establish an allotment level pursuant to section (1) of this rule. The Chief Financial Office shall notify each agency of the action taken.

Stat.Auth.: ORS 194.340
Stats. Implemented: OL 2013 (SB 5504)
Hist.: BMD 1-2013(Temp), f. & cert. ef. 6-27-13 thru 8-15-13

Department of Agriculture
Chapter 603

Rule Caption: Establishes limitations on sites where the pesticide dinotefuran may be applied or used.
Adm. Order No.: DOA 8-2013(Temp)
Filed with Sec. of State: 6-27-2013
Certified to be Effective: 6-27-13 thru 12-24-13
Notice Publication Date:
Rules Adopted: 603-057-0386
Subject: Establishes limitations, for the protection of pollinating insects on where pesticide products containing the active ingredient dinotefuran may be applied or used.
Rules Coordinator: Sue Gooch—(503) 986-4583

603-057-0386
Dinotefuran

(1) Any application, regardless of application method, of a pesticide product containing the active ingredient dinotefuran on plants is prohibited. This includes, but is not limited to, applications on landscape trees and shrubs, nursery and greenhouse plants, turfgrass, forests and agricultural crops.

(2) Failure to comply with section (1) above may result in one or more of the following actions:

(a) Revocation, suspension or refusal to issue or renew the license or certification of an applicant, licensee or certificate holder;

(b) Imposition of a civil penalty;

(c) Any other enforcement action authorized under any law.

Stat. Auth: ORS 183, 561.020, 634.322(6), 634.900
Stats. Implemented: ORS 634
Hist.: DOA 8-2013(Temp), f. & cert. ef. 6-27-13 thru 12-24-13

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Department of Agriculture, Oregon Dungeness Crab Commission
Chapter 645

Rule Caption: Adjusts the date monthly crab assessment fees and reports are due to ODCC office.
Adm. Order No.: ODCC 1-2013
Filed with Sec. of State: 6-24-2013
Certified to be Effective: 7-5-13
Notice Publication Date: 6-1-2013
Rules Amended: 645-010-0015
Subject: First purchasers and handlers must submit completed and signed assessment reports on commission-approved forms. Assessment reports shall include all purchases by or deliveries to a first purchaser of Oregon Dungeness Crab in the previous month. Assessment reports are due in the commission office by 5:00 p.m. on the 30th day of each month for all purchases or deliveries of Oregon Dungeness Crab in the previous month. Penalties and interest will apply on the first day of the month following the due date. EXAMPLE: Assessment reports and fees are due on April 30th for March purchases and deliveries. Penalties and interest will be applied on May 1st.
Rules Coordinator: Shirley D. Williams—(541) 267-5810

645-010-0015
Reports and Payment of Assessment Moneys

First purchasers and handlers must submit completed and signed assessment reports on commission-approved forms. Assessment reports shall include all purchases by or deliveries to a first purchaser of Oregon Dungeness Crab in the previous month. Assessment reports are due in the commission office by 5:00 p.m. on the 30th day of each month for all purchases or deliveries of Oregon Dungeness Crab in the previous month. Penalties and interest will apply on the first day of the month following the due date.

EXAMPLE: Assessment reports and fees are due on April 30th for March purchases and deliveries. Penalties and interest will be applied on May 1st.

Stat. Auth: ORS 183
Stats. Implemented: ORS 576.335(1) & 576.304(14)
Hist.: DCC 2, f. 12-28-77, ef. 1-1-78; ODCC 1-2000, f. & cert. ef. 12-15-00; ODCC 1-2010(Temp), f. & cert. ef. 2-23-10 thru 7-31-10; Administrative correction 8-18-10; ODCC 1-2013, f. 6-24-13, cert. ef. 7-5-13

Rule Caption: Amends per diem rate for Oregon Dungeness Crab commissioners from $30.00 to $100.00.
Adm. Order No.: ODCC 2-2013
Filed with Sec. of State: 6-24-2013
Certified to be Effective: 7-5-13
Notice Publication Date: 6-1-2013
Rules Amended: 645-040-0010
Subject: Sets per diem for commissioners at $100.00 for each day spent on official commission duties; requires reporting time spent and nature of duties performed. The 2009 Oregon Legislature approved HB 2458 which amended ORS 576.265 to exempt commodity commissions from the per diem limits set in OAR 292.495. At Oregon Dungeness Crab Commission meetings dated January 27, 2010, April 12, 2013 and June 24, 2013 motions were made and Commission approved to file and adopt this rule.
Rules Coordinator: Shirley D. Williams—(541) 267-5810

645-040-0010
Per Diem Compensation

(1) Subject to the availability of funds in the budget of the commission, the Oregon Dungeness Crab Commission must pay any member of the commission, other than a member who is employed in full-time public service, compensation for each day or portion thereof during which the member is actually engaged in the performance of official commission duties.

(2) Sets per diem for commissioners at $100. The 2009 Oregon Legislature approved HB 2458 which amended ORS 576.265 to exempt commodity commissions from the per diem limits set in OAR 292.495.

(3) In order to receive compensation, a member must submit to the Oregon Dungeness Crab Commission a written claim for compensation by the 1st day of the calendar month following the month for which the member seeks compensation. The member must specify the amount of time the member spent on official commission duties as well as the nature of the duties performed for any day or portion thereof for which the member claims compensation.

Stat. Auth.: ORS 576.304
Stats. Implemented: ORS 576.265
Hist.: ODCC 1-2007, f. & cert. ef. 9-13-07; ODCC 2-2013, f. 6-24-13, cert. ef. 7-5-13

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Department of Agriculture, Oregon Potato Commission
Chapter 658

Rule Caption: Changes commissioner regional qualifications, also reduces waiting period to appoint new commissioner to unfilled position
Adm. Order No.: OPC 1-2013
Filed with Sec. of State: 7-3-2013
Certified to be Effective: 7-3-13
Notice Publication Date: 6-1-2013
Rules Amended: 658-030-0020
Subject: Potato production has declined in Malheur and Harney counties reducing the amount of representation needed in that region. Other counties have increased in production during the same time period necessitating an increase in representation. The decrease in one region and an increase in another facilitate a need for member qualification changes.

Two changes are being made to the commission member qualifications. In section (3)(b), the number of commission appointments from the Malheur area is reduced from two to one and in section (3)(f) one at-large appointment from any of the major potato producing areas of the state is newly created.

In section (4) the minimum time limit a position is vacant before appointing a person at large that may reside anywhere within the State, is being changed from one year to 30 days following reasonable efforts to recruit a member from a particular region.

The commission does not expect any economic impact from these commissioner appointment qualification changes
Rules Coordinator: Jennifer Fletcher—(503) 239-4763

658-030-0020
Qualifications of Commissioners

(1) For purposes of this rule:

(a) A "producer" is a person growing or producing within this state or procuring within the state, its rivers or the offshore waters, but not the Columbia River, for commercial handling within the state, a commodity for market, or receiving a share thereof as landowner, landlord, tenant, sharecropper, boat skipper or otherwise. A producer must have paid the commission assessment on the commodity in each of the preceding three calendar years.

(b) A "handler" is any producer, processor, distributor or other person engaged in handling or marketing of or dealing in the commodity, whether as owner, agent, employee, broker or otherwise. A handler must have collected the commission assessment, if any, each of the preceding three calendar years.

(2) Members of the Potato Commission will have the following qualifications, which will continue during the term of office of the member:

(a) One member of the commission will be a member of the public with an active interest in the positive economic development, production and/or marketing of the commodity, but who is not associated with the production or handling of potatoes;

(b) A majority of the members will be producers;

(c) At least one member will be a handler;

(d) All members who are not a handler or the public member will be producers.

(3) In addition to the qualifications set forth in subsection (2) of this rule, the appointments shall be made so that each major potato-producing area of the state is represented as follows:

(a) Three from the Blue Mountain area, comprised of the counties of Baker, Union, Wallowa, Grant, Morrow and Umatilla.

(b) One from the area comprised of Malheur and Harney Counties.

(c) One from central Oregon, comprised of the counties of Crook, Deschutes, Gilliam, Sherman, Wasco, Wheeler and Jefferson.

(d) Two from the area comprised of Klamath, Coos, Curry, Douglas, Jackson, Josephine and Lake counties.

(e) One from the Willamette Valley area, comprised of the counties of Benton, Clackamas, Clatsop, Columbia, Hood River, Lincoln, Lane, Linn, Marion, Multnomah, Polk, Tillamook, Yamhill and Washington.

(f) One at-large member from any of the major potato-producing areas of the state.

(g) One as a member of the public.

(4) Notwithstanding subsection (3) of this section, if a position remains vacant for more than 30 days following reasonable efforts to recruit a member from a particular region, a person may be appointed at large and may reside anywhere within the State of Oregon. Once that person's term expires and he or she is not reappointed, the position will again be subject to the geographic qualification requirements of subsection (3) of this section.

Stat. Auth.: 2003 OL Ch. 604 & ORS 576
Stats. Implemented: 2003 OL Ch. 604 & ORS 576
Hist.: OPC 1-2003, f. & cert. ef. 12-4-03; OPC 1-2013, f. & cert. ef. 7-3-13

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Department of Community Colleges and Workforce Development
Chapter 589

Rule Caption: Two Plus Two and Dual Credit Programs
Adm. Order No.: DCCWD 4-2013
Filed with Sec. of State: 6-25-2013
Certified to be Effective: 6-25-13
Notice Publication Date: 6-1-2013
Rules Amended: 589-007-0200
Subject: Currently, two separate rules influence faculty qualifications in Oregon community colleges. One is specific to instructors of dual credit program and one is a general rule for all faculty. Both rules have been in existence for over 30 years. With the 40-40-20 goal (included in Senate Bill 253 (June 2011)), and a focus on achievement compacts and alignment of secondary to postsecondary education, the agency proposes to amend the administrative rule to provide clear and concise alignment of the rules.
Rules Coordinator: Linda Hutchins—(503) 947-2456

589-007-0200
Two Plus Two and Dual Credit Programs

(1) For purposes of this rule, the following definitions apply:

(a) "Two Plus Two" means planned career and professional technical programs articulated between high schools and community colleges.

(b) "Dual Credit" means awarding secondary and postsecondary credit for a course offered in a high school during regular school hours, as determined by local school board and community college board policy.

(2) Before developing programs with high schools, each college shall file with the Department a policy for governing Two Plus Two and Dual Credit programs. Policies must include the following:

(a) Institutional standards for instructor qualifications (standards for teachers of lower division collegiate courses must include a master's degree in a subject area closely related to that in which the instructor will be teaching; however, in subject areas in which individuals have demonstrated their competencies and served in professional fields, and in cases in which documentation to support the individual's proficiency and high level of competency can be assembled, the master's degree requirement may be waived by the college president or substituted according to the community college's personnel policy);

(b) Methods for selecting student participants, including limiting classes to seniors and qualified juniors, and in exceptional cases other qualified students. Qualifications must be defined;

(c) Assurances that classes will be transcripted by the community college;

(d) Assurances that materials and subject matter are community college level.

(3) On or before October 1 of each year, community colleges shall submit an annual evaluation of the previous school year's Two Plus Two and Dual Credit programs, including but not limited to descriptions of:

(a) Programs and courses offered;

(b) Student outcomes;

(c) Instructors' qualifications; and

(d) Program costs.

(4) Participating school districts and post-secondary institutions shall develop written agreements based on the policies described in this rule regarding Two Plus Two and Dual Credit programs, which include:

(a) Criteria regarding approval of courses, selection and approval of instructors, admissions, procedures, counseling, monitoring, and evaluation; and

(b) The provision that all agreements and policies shall be available to all staff members involved in the programs and to parents and students.

(5) Participating school districts and postsecondary institutions shall, in consultation with appropriate staff members, determine that course content and instructional quality are consistent with that offered by the community colleges.

(6) The Commissioner shall require an accounting of FTE consistent with these rules.

Stat. Auth.: ORS 326.051

Stats. Implemented: ORS 329.475, 329.855, 341.42, 341.450, 341.525(3) & 341.535

Hist.: 1EB 10-1981, f. 5-6-81, ef. 5-7-81; EB 14-1991, f. & cert. ef. 7-19-91; Renumbered from 581-042-0088; DCCWD 1-2001, f. & cert. ef. 3-21-01, Renumbered from 581-043-0510; DCCWD 1-2003, f. & cert. ef. 1-9-03; DCCWD 5-2003, f. & cert. ef. 10-20-03; DCCWD 4-2013, f. & cert. ef. 6-25-13

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Department of Consumer and Business Services, Insurance Division
Chapter 836

Rule Caption: Rating and filing requirements for individual and small employer health benefit plan rate filings
Adm. Order No.: ID 4-2013(Temp)
Filed with Sec. of State: 6-17-2013
Certified to be Effective: 6-17-13 thru 12-6-13
Notice Publication Date:
Rules Adopted: 836-053-0064
Rules Amended: 836-053-0065, 836-053-0471
Subject: This rule suspends a requirement that health insurers include, as a component of a small employer or individual health benefit plan rate filing, a document containing, among other important disclosures, summary information breaking down the expenditure of premium contributions, and further breaking down expenditures on medical claims. The form is similar to a federal form that insurers must file. To eliminate duplication of effort as rate filings are received for the start of the Oregon Health Insurance Exchange Corporation operation, the state will rely on the forms required to be filed by federal law. New provisions for rating of grandfathered and nongrandfathered health benefit plans reflect changes required under federal law for nongrandfathered small group plans and the need to distinguish the rating requirements for grandfathered and nongrandfathered plans. It is necessary to make these changes immediately in order to have correct rules in place as the department makes decisions about the approval or disapproval of rates and plans for plans effective on or after January 1, 2014.
Rules Coordinator: Victor Garcia—(503) 947-7484

836-053-0064
Rating for Nongrandfathered Small Group Plans

The following provisions relating to rating apply to nongrandfathered health benefit plans offered to small employers:

(1) A small employer carrier shall file a single geographic average rate for each nongrandfathered health benefit plan that is offered to small employers within a geographic area and for each category of family composition. The geographic rate must be determined on a pooled basis and the pool shall only include all of the carrier's nongrandfathered business in the small employer market.

(2) There shall be one rating class for each small employer carrier. All nongrandfathered small employer health benefit plans of the carrier shall be rated in that class. A rating of a health benefit plan is subject to adjustments reflecting age, tobacco use and differences in family composition.

(3) The variation in geographic average rates among different nongrandfathered small employer health benefit plans offered by a carrier must be based solely on objective differences in plan design or coverage. The variation shall not include differences based on the risk characteristics or claims experience of the actual or expected enrollees in a particular plan.

(4) A small employer carrier shall file its geographic average rates for nongrandfathered small employer health benefit plans in accordance with the rate filing requirements of OAR 836-053-0910.

(5) A small employer carrier shall assess administrative expenses in a uniform manner to all nongrandfathered small employer health benefit plans. Administrative expenses shall be expressed as a percentage of premium and the percentage may not vary with the size of the small employer.

(6) Nongrandfathered small group plans shall be rated within the following geographic areas comprising counties as follows:

(a) Area 1 shall include: Clackamas, Multnomah, Washington, and Yamhill;

(b) Area 2 shall include: Benton, Lane, and Linn;

(c) Area 3 shall include: Marion and Polk;

(d) Area 4 shall include: Deschutes, Klamath, and Lake;

(e) Area 5 shall include: Clatsop, Columbia, Coos, Curry, Lincoln, and Tillamook;

(f) Area 6 shall include: Baker, Crook, Gilliam, Grant, Harney, Hood River, Jefferson, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco, and Wheeler.

(g) Area 7 shall include: Douglas, Jackson and Josephine.

(7) For nongrandgathered small group plans, a small employer carrier may use the same geographic average rate for multiple rating areas.

(8) Premium rates for nongrandfathered small employer health benefit plans:

(a) For each group, shall total the sum of the product of the base rate and the applicable factors in section (9) of this rule for each employee and dependent 21 years of age and older and the sum of the product of the base rate and the applicable factors in section (9) of this rule for each of the three oldest dependent children under the age of 21 within each family in the group.

(b) Shall be allocated to an employee by dividing the total premium described in subsection (a) of this section by the sum of the products of the number of employees and the applicable tier factors specified in paragraphs (A) through (D) of this subsection, and multiplying the quotient by the applicable tier factor for the employee as specified in paragraphs (A) through (D) of this subsection. The tier factors are:

(A) 1.00 for an employee only;

(B) 1.85 for an employee and one or more children age 25 or younger;

(C) 2.00 for an employee and spouse; and

(D) 2.85 for an employee and family.

(9) The variations in rates described in this rule may be based on one or more of the following factors as determined by the carrier:

(a) The ages of enrolled employees and their dependents according to Exhibit 1 to this rule. Variations in rates based on age may not exceed a ratio of 3 to 1.

(b) A tobacco use factor of no more than 1.5 times the non-tobacco use rate for persons 18 years or older except that the factor may not be applied when the person is enrolled in a tobacco cessation program.

(c) The level at which enrolled employees and their dependents engage in health promotion, disease prevention or wellness programs.

Stat. Auth.: ORS 731.244 & 743.731 & 743.758
Stats. Implemented: ORS 743.731, 743.734 & 743.737
Hist.: ID 4-2013(Temp), f. & cert. ef. 6-17-13 thru 12-6-13

836-053-0065
Rating for Grandfathered Small Group Plans

The following provisions relating to rating apply to grandfathered health benefit plans offered to small employers:

(1) A small employer carrier shall file a single geographic average rate for each grandfathered health benefit plan that is offered to small employers within a geographic area and for each category of family composition. The geographic average rate must be determined on a pooled basis and the pool shall include all of the carrier's grandfathered business in the small employer market.

(2) There shall be one rating class for each small employer carrier. All grandfathered small employer health benefit plans of the carrier shall be rated in that class. A rating of a grandfathered health benefit plan is subject to adjustments reflecting the level of benefits provided and differences in family composition and age.

(3) The variation in geographic average rates among different grandfathered small employer health benefit plans offered by a carrier must be based solely on objective differences in plan design or coverage. The variation shall not include differences based on the risk characteristics or claims experience of the actual or expected enrollees in a particular plan, except that a carrier may make further adjustment at renewal to reflect the expected claims experience of the covered small employer; however, this adjustment may not exceed five percent of the annual premium otherwise payable by the small employer, is not cumulative year to year, and may be based only on the carrier's claims experience with the small employer. A variation based on the level of contribution by the small employer or on the level of participation by eligible employees, or on both, must be actuarially sound.

(4) A small employer carrier shall file its geographic average rates for grandfathered small employer health benefit plans in accordance with the rate filing requirements of OAR 836-053-0910.

(5) A small employer carrier shall assess administrative expenses in a uniform manner to all grandfathered small employer health benefit plans. Administrative expenses shall be expressed as a percentage of premium and the percentage may not vary with the size of the small employer.

(6) Grandfathered small employer plans shall be rated within the following geographic areas comprising counties as follows:

(a) Area 1 shall include: Clackamas, Multnomah, Washington, and Yamhill;

(b) Area 2 shall include: Benton, Lane, and Linn;

(c) Area 3 shall include: Marion and Polk;

(d) Area 4 shall include: Deschutes, Klamath, and Lake;

(e) Area 5 shall include: Clatsop, Columbia, Coos, Curry, Lincoln, and Tillamook;

(f) Area 6 shall include: Baker, Crook, Gilliam, Grant, Harney, Hood River, Jefferson, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco, and Wheeler.

(g) Area 7 shall include: Douglas, Jackson and Josephine.

(7) For grandfathered small employer plans, a small employer carrier may use five digit zip code groupings to define the carrier's geographic areas. The zip code groupings may vary from the county areas defined in section (6) of this rule by no more than ten percent of the population of a county. The small employer carrier must use either the zip code system or the county system and shall not modify the geographic areas in any other manner.

(8) For grandfathered small employer plans, a small employer carrier may use the same geographic average rate for multiple rating areas.

(9) For grandfathered small employer plans, a small employer carrier may deviate from the variation described in section (1) of this rule for coverage that extends to a geographic area outside the state of Oregon. The carrier must do so in a reasonable fashion and maintain records regarding the basis for the rate charged in the small employer's file.

(10) The premium rates charged during a rating period for a grandfathered health benefit plan issued to a small employer may not vary from the geographic average rate by more than 50.0 percent

(11) The variations in premium rates described in section (10) of this rule may be based on one or more of the following factors as determined by the carrier:

(a) The ages of enrolled employees and their dependents;

(b) The level at which the small employer contributes to the premiums payable for enrolled employees and their dependents;

(c) The level at which eligible employees participate in the health benefit plan;

(d) The level at which enrolled employees and their dependents engage in tobacco use;

(e) The level at which enrolled employees and their dependents engage in health promotion, disease prevention or wellness programs;

(f) The period of time during which a small employer retains uninterrupted coverage in force with the same small employer carrier; and

(g) Adjustments to reflect the level of benefits provided and differences in family composition.

Stat. Auth.: ORS 731.244 & 743.731
Stats. Implemented: ORS 743.731, 743.734 & 743.737
Hist.: ID 17-1992, f. 12-3-92, cert. ef. 12-7-92; ID 1-1994, f. & cert. ef. 1-26-94; ID 12-1996, f. & cert. ef. 9-23-96; Renumbered from 836-053-0020; ID 5-1998, f. & cert. ef. 3-9-98; ID 5-2000, f. & cert. ef. 5-11-00; ID 5-2007(Temp), f. 8-17-07, cert. ef. 8-20-07 thru 2-15-08; ID 2-2008, f. & cert. ef. 2-11-08; ID 4-2013(Temp), f. & cert. ef. 6-17-13 thru 12-6-13

836-053-0471
Required Materials for Rate Filing for Individual or Small Employer Health Benefit Plans

(1) Every insurer that offers a health benefit plan for small employers or an individual health benefit plan covering an Oregon resident shall file the information specified in subsections (2) and (3) of this rule when the insurer files with the director a schedule or table of premium rates for approval.

(2) A schedule or table of base premium rates filed under subsection (1) of this section shall include sufficient information and data to allow the director to consider the factors set forth in ORS 743.018(4) and (5). The filing shall include all of the following separately set forth and labeled as indicated:

(a) A filing description.

(A) Label: FILING DESCRIPTION.

(B) The filing description shall be submitted in the form of a cover letter. The filing description must provide a summary of the reasons an insurer is requesting a rate change and the minimum and maximum rate impact to all groups or members affected by the rate change, including the anticipated change in number of enrollees if the proposed premium rate is approved. The description also must include the name and contact information of the filer and a description of any significant changes the insurer is making to the following:

(i) Rating factor changes;

(ii) Plan modification or discontinuance; and

(iii) Benefit or administration changes.

(b) A rate filing summary.

(A) Label: RATE FILING SUMMARY.

(B) This summary must explain the filing in a manner that allows consumers to understand the rate change. The summary shall be in accordance with the form established in Exhibit 1 or Exhibit 2 to this rule. The information contained in this summary must match the information provided elsewhere in the filing.

(c) An actuarial memorandum.

(A) Label: ACTUARIAL MEMORANDUM.

(B) This memorandum must include all of the following:

(i) A description of the benefit plan and a quantification of any changes to the benefit plan as set forth in subsection (j) of this section.

(ii) A discussion of assumptions, factors, calculations, rate tables and any other information pertinent to the proposed rate.

(iii) A description of any changes in rating methodology supported by sufficient detail to permit the department to evaluate the effect on rates and the rationale for the change.

(iv) The range of rate impact to groups or members including the distribution of the impact on members.

(v) Signature of and date that a qualified actuary reviewed the rate filing.

(d) Rate tables and factors.

(A) Label: RATE TABLES AND FACTORS.

(B) The insurer must include base and geographic average rate tables, identify factors used by the insurer in developing the rates and explain how the information is used in the development of rates. The rate tables and factors must include a table of rating factors reflecting ages of employees and dependents and geographic area. If base rates are not provided by rating tier, the rate tier tables also must be provided.

(C) The document must indicate whether the rate increases are the same for all policies. The document must clearly explain how the rate increases apply to different policies including the entire distribution of rate

changes and the average of the highest and lowest rates resulting from the application of other rating factors.

(D) The geographic average rate table must include family type, geographic area and the average of the highest and lowest rates resulting from the application of other rating factors.

(E) The rate tables must contain at a minimum the base rates for each available plan. This document must include information that would permit the determination of rates for each benefit plan, each age bracket, each geographic area, each rate tier and any other variable used to determine rates. If the rates vary more frequently than annually, separate rates must either be provided for each effective date of change or information provided to permit their determination and the justification for such variation in rates.

(F) If the filing is for a health benefit plan issued to a small employer, the insurer also shall include the following factors if applied by the insurer as allowed under ORS 743.737:

(i) Contribution;

(ii) Level of participation;

(iii) Tobacco usage;

(iv) Participation in wellness programs;

(v) Duration of coverage in force; and

(vi) Any adjustment to reflect expected claims experience, which may not exceed the limits established in ORS 743.737.

(e) Plan relativities.

(A) Label: PLAN RELATIVITIES.

(B) This document must explain the presentation of rates for each benefit plan, explain the methodology of how the benefit plan relativities were developed and demonstrate the comparison and reasonableness of benefits and costs between plans.

(f) A description of the development of the proposed rate change or base rate.

(A) Label: DEVELOPMENT OF RATE CHANGE OR BASE RATE.

(B) This document is the core of the rate filing and must explain how the proposed rate or rate change was calculated. The calculation must be based on generally accepted actuarial rating principles for rating blocks of business and should provide sufficient detail to allow reasonable review. The development of rate change or base rate also should include actual or expected membership information and identify a proposed loss ratio for the rating period. A rate renewal calculation must begin with an assumed experience period of at least one year ending within the immediately preceding year, or, if more recent data is available for one-year period that concludes with the most recent period for which data is available. The total premium earned during the experience period should be adjusted to yield premium adjusted to current rates. A projection is made of premiums and claims for the period during which the proposed rates are to be effective. Claims for a renewal projection should reflect an assumed medical trend rate as well as other expected changes in claims cost, including but not limited to the impact of benefit changes or provider reimbursement.

(g) Trend information and projection.

(A) Label: TREND INFORMATION AND PROJECTION.

(B) This document must describe how the assumed future growth of medical claims (the medical trends rate) was developed based on generally accepted actuarial principles. The trend document also must include historical monthly average claim costs for at least the immediately preceding two years when applicable. If the carrier's structure does not include claims cost, the carrier shall submit this information based on allocated costs.

(h) Premium retention.

(A) Label: PREMIUM RETENTION.

(B) This document must include a description of retention. As used in this paragraph, "retention" means the amount to be retained by the insurer to cover all of the insurer's non-claim costs including expected profit or contribution to surplus for a nonprofit entity. Retention must be reported on a percentage of premium basis.

(i) Worksheet for Individual Health Benefit Plan Rates (if applicable).

(A) Label: WORKSHEET FOR INDIVIDUAL HEALTH BENEFIT PLAN RATES.

(B) This standardized schedule for individual health benefit plan rates must include earned premiums, incurred claims and membership totals for the past five years on an annual basis as well as accumulated to the current date. The same elements must be projected and reported for each of the next three years. If an active life reserve has been established, that reserve also should be included.

(j) Changes to covered benefits or health benefit plan design.

(A) Label: COVERED BENEFIT OR PLAN DESIGN CHANGES.

(B) This document must explain benefit and administrative changes with rating impact, including covered benefit level changes, member cost-sharing changes, elimination of plans, implementation of new plan designs, provider network changes, new utilization or prior authorization programs, changes to eligibility requirements, changes to exclusions, or any other change in the plan offerings that impacts costs or coverage provided.

(k) Changes in the insurer's health care cost containment and quality improvement efforts.

(A) Label: COST CONTAINMENT AND QUALITY IMPROVEMENT EFFORTS.

(B) This document must explain any changes the insurer has made in its health care cost containment efforts and quality improvement efforts since the insurer's last rate filing for the same category of health benefit plan. Significant new health care cost containment initiatives and quality improvement efforts should be described and an estimate made of potential savings together with an estimated cost or savings for the projection period. The insurer shall provide information about whether the cost containment initiatives reduce costs by eliminating waste, improving efficiency, by improving health outcomes through incentives, or by elimination or reduction of covered services or reduction in the fees paid to providers for services.

(l) Information about the insurer's financial position.

(A) Label: INSURER'S FINANCIAL POSITION.

(B) This document must include information about the insurer's financial position, including but not limited to profitability, surplus, reserves and investment earnings. This document also must include a discussion of whether the proposed change in the premium rate is necessary to maintain the insurer's solvency or to maintain rate stability and prevent excessive rate increases for the line of business in the future. In providing this information, the insurer may reference documents filed with the department as part of the annual statement or other requisite filings. The referenced material must be available to the public.

(m) Certification of compliance.

(A) Label: CERTIFICATION OF COMPLIANCE.

(B) The certificate must comply with OAR 836-010-0011 and must certify that the filing complies with Oregon statutes, rules, product standards and filing requirements.

(n) Third party filer's letter of authorization (if applicable).

(A) Label: THIRD PARTY AUTHORIZATION.

(B) If the filing is submitted by a person other than the insurer, the filing must include a letter from the insurer that authorizes the third party to submit and correspond with the department on matters pertaining to the rate filing.

(3)(a) For each schedule or table of premium rates filed, the insurer shall separately include a statement of administrative expenses for the line of business and complete the chart displaying the five-year trend of administrative costs included as Exhibit 3 to this rule. The chart must break down the insurer's administrative expenses relating to:

(A) Salaries, wages, employment taxes and other benefits;

(B) Commissions;

(C) Cost depreciations including but not limited to depreciation for equipment, software or furniture;

(D) Rent or occupancy expenses;

(E) Marketing and advertising;

(F) General offices expenses, including but not limited to sundries, supplies, telephone, printing and postage;

(G) Third party administration expenses or fees or other group service expense or fees;

(H) Legal fees and expenses and other professional or consulting fees;

(I) Other taxes, licenses and fees; and

(J) Travel expenses.

(b) The statement of administrative expenses required under this subsection must include:

(A) As set forth in Exhibit 3, a statement of administrative expenses on a per member per month basis set forth separately for claim-related and non-claim expenses;

(B) As set forth in Exhibit 3, an explanation of the basis for any proposed premium rate increase or decrease related to changes in the administrative expenses of the insurer; and

(C) An explanation of how the insurer allocates administrative expenses for the filed line of business.

(4)(a) Within 10 days after receiving a proposed table or schedule of premium rate filing, the director shall:

(A) Determine whether the proposed table or schedule of premium rate filing is complete. If the director determines that a filing is complete, the director shall review the proposed schedule or table of premium rate in accordance with ORS 742.003, 742.005, 742.007 and 743.018. If the direc-

tor determines that the filing is not complete, the director shall notify the insurer in writing that the filing is deficient and give the insurer an opportunity to provide the missing information.

(B) If the filing is complete, the director shall open the 30-day public comment period. For purposes of determining the beginning of the public comment period, the date the carrier files a proposed schedule or table of premium rates shall be the date the director determines that the filing is complete.

(b) The director shall issue a decision approving, disapproving or modifying the proposed table or schedule of premium rate filing within 10 days after the close of the public comment period.

(5) The director shall post on the Insurance Division website all materials submitted under subsections (2) and (3) of this rule at the beginning of the public comment period.

Stat. Auth.: ORS 731.244, 743.018, 743.019 & 743.020
Stats. Implemented: ORS 742.003, 742.005, 742.007, 743.018, 743.019, 743.020, 743.730 & 743.767
Hist.: ID 5-2010, f. & cert. ef. 2-16-10; ID 14-2012, f. & cert. ef. 8-1-12; ID 4-2013(Temp), f. & cert. ef. 6-17-13 thru 12-6-13

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Department of Consumer and Business Services, Workers' Compensation Division
Chapter 436

Rule Caption: Self-insured employer groups, common claims fund balance
Adm. Order No.: WCD 5-2013
Filed with Sec. of State: 7-3-2013
Certified to be Effective: 7-22-13
Notice Publication Date: 4-1-2013
Rules Amended: 436-050-0003, 436-050-0300
Subject: These rules replace temporary rules currently in effect and decrease the funding requirement for the common claims fund, for self-insured employer groups that are not made up of governmental subdivisions, from 100 percent to 30 percent of the average of the group's paid losses for the previous four years.
Rules Coordinator: Fred Bruyns—(503) 947-7717

436-050-0003
Applicability of Rules

(1) These rules are effective July 22, 2013, to carry out the provisions of:

(a) ORS 656.017 — Employer required to pay compensation and perform other duties.

(b) ORS 656.029 — Independent contractor status.

(c) ORS 656.126 — Coverage while temporarily in or out of state.

(d) ORS 656.407 — Qualifications of insured employers.

(e) ORS 656.419 — Workers' compensation insurance policies.

(f) ORS 656.423 — Cancellation of coverage by employer.

(g) ORS 656.427 — Cancellation of workers' compensation insurance policy or surety bond liability by insurer.

(h) ORS 656.430 — Certification of self-insured employer.

(i) ORS 656.434 — Certification effective until canceled or revoked; revocation of certificate.

(j) ORS 656.443 — Procedure upon default by employer.

(k) ORS 656.447 — Sanctions against insurer for failure to comply with orders, rules, or obligations under workers' compensation insurance policies.

(l) ORS 656.455 — Records location and inspection.

(m) ORS 656.745 — Civil penalties.

(n) ORS 656.850 and 656.855 — Worker leasing companies.

(o) ORS 731.475 — Insurer's in-state location.

(2) The director may waive procedural rules as justice requires, unless otherwise obligated by statute.

Stat. Auth: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.017, 656.029, 656.126, 656.407, 656.419, 656.423, 656.427, 656.430, 656.434, 656.443, 656.447, 656.455, 656.745, 656.850, 656.855 & 731.475
Hist.: WCD 3-1980(Admin), f. & ef. 4-2-80; WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 10-1982(Admin), f. 9-30-82, ef. 10-1-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; Renumbered from 436-051-0003, 1-1-86; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 25-1990, f. 11-29-90, cert. ef. 12-26-90; WCD 3-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 2-1994, f. 4-1-94, cert. ef. 5-1-94; WCD 9-1996, f. 3-11-96, cert. ef. 4-1-96; WCD 1-1998, f. 1-9-98, cert. ef. 1-23-98; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 10-2003, f. 8-29-03, cert. ef. 9-15-03; WCD 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 5-2005, f. 5-26-05, cert. ef. 6-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 7-2007, f. 11-1-07, cert. ef. 11-28-07; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 4-2008, f. 9-17-08, cert. ef. 7-1-09; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 1-2013(Temp), f. & cert. ef. 1-23-13 thru 7-21-13; WCD 5-2013, f. 7-3-13, cert. ef. 7-22-13

436-050-0300
Self-Insured Employer Group, Common Claims Fund

(1) A self-insured employer group must establish, under the direction and control of the board of trustees and administrator, a common claims fund for the sole purpose of ensuring the availability of funds to make certain the prompt payment of all compensation and all other payments that may become due from such self-insured employer group under the workers' compensation law.

(2) Except as provided in section (5) of this rule, the balance of the common claims fund must be maintained in an amount at least equal to 30 percent of the average of the group's paid losses for the previous four years.

(3) The director may require the self-insured group to increase the amount maintained in the common claims fund.

(4) By March 1 of each year, a self-insured employer group must provide the director with adequate documentation to validate the balance in the common claims fund or notice that the amount calculated in section (2) or (5) of this rule must be included in the determination of the self-insured employer group's security deposit under OAR 436-050-0180.

(5) For governmental subdivisions certified as a self-insured employer group, the balance of the common claims fund must be maintained in an amount at least equal to 60 percent of the average of the group's yearly paid losses for the previous four years.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.430
Hist.: WCD 4-1982(Admin), f. 2-10-82, ef. 2-15-82; WCD 7-1983(Admin), f. 12-22-83, ef. 12-27-83; WCD 5-1985(Admin), f. 12-10-85, cert. ef. 1-1-86; Renumbered from 436-051-0420; WCD 9-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 9-1987, f. 12-18-87, ef. 1-1-88; WCD 7-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 5-2001, f. 6-22-01, cert. ef. 7-1-01; WCD 6-2012, f. 10-4-12, cert. ef. 1-1-13; WCD 1-2013(Temp), f. & cert. ef. 1-23-13 thru 7-21-13; WCD 5-2013, f. 7-3-13, cert. ef. 7-22-13

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Department of Corrections
Chapter 291

Rule Caption: Use of Force and Security Equipment by DOC Employees
Adm. Order No.: DOC 6-2013
Filed with Sec. of State: 6-21-2013
Certified to be Effective: 6-21-13
Notice Publication Date: 5-1-2013
Rules Amended: 291-013-0010, 291-013-0055, 291-013-0070, 291-013-0104, 291-013-0110, 291-013-0130, 291-013-0140, 291-013-0206, 291-013-0215
Subject: These amendments are necessary to remove language for the pepperball launching system, as this security equipment is no longer used within DOC; revise the process for preliminary reviews on use of force incidents to promote efficiencies; and other housekeeping items to update the language to current terminology and reflect organizational changes that have occurred since the last revision.
Rules Coordinator: Janet R. Worley—(503) 945-0933

291-013-0010
Definitions

(1) Carotid Hold: Application of a hold to the neck that restricts deoxygenated blood leaving the brain, which may result in the person to whom it is applied becoming unconscious.

(2) Chemical Agents: Chemical compounds that when deployed are designed to cause sufficient physiological effect to stop, control or temporarily incapacitate an individual.

(3) Choke Hold: Application of physical pressure applied directly to the neck area to restrict air from entering the lungs.

(4) Co-Located Minimum Security Facility/Level 2: A minimum security facility on the grounds of a medium or higher security facility, but not within the fenced perimeter of this higher security facility.

(5) Corporal Punishment: The use of physical force for the purpose of punishment.

(6) Department of Corrections Facility: Any institution, facility or staff office, including the grounds, operated by the Department of Corrections.

(7) Electronic Control Devices: Security equipment designed to stop, control or temporarily incapacitate through the use of high voltage, low amperage electric stimulation; e.g., conducted electrical weapons, electronic shield, etc.

(8) Excessive Force: A type or amount of force beyond that which is reasonably necessary to control the situation and achieve the correctional

objective; or the continued use of force after it is no longer reasonably necessary.

(9) Functional Unit Manager: Any person within the Department of Corrections who reports to the Director, an Assistant Director or administrator and has responsibility for delivery of program services or coordination of program operations.

(10) Hogtie Method: Binding a person's wrists and ankles together behind the back while in a prone position.

(11) Less Lethal Force: Systems that are explicitly designed and primarily employed so as to incapacitate while minimizing fatalities or permanent injury.

(12) Lethal Force: Physical force that has substantial risk of causing death.

(13) Level of Force: The type of force employed, amount of that type of force employed, and the circumstances within which the force is employed.

(14) Medium or Higher Security Facility/Level 3 or Higher: A medium or higher security facility may house multiple custody classifications of inmates within its secure perimeter, including custody Level 1 and 2 inmates. Medium or higher security facilities will treat all inmates as if they are classified Level 3 or higher custody.

(15) Negligent Discharge: An unintentional discharge caused by an action or event that an employee could and should have foreseen or prevented.

(16) Officer-in-Charge: That person designated by the functional unit manager to supervise and make operational decisions in accordance with department policy, rule or procedure during periods when the functional unit manager or officer-of-the-day is not readily available.

(17) Physical Force: The use of hands, other parts of the body, objects, instruments, chemical devices, electronic devices, firearms or other physical methods used to restrain, subdue, control, intimidate or to compel persons to act in a particular way, or to stop acting in a particular way.

(18) Planned Use of Force: The use of force in situations where time and circumstances allow for consultation and approval with higher ranking employees, and where there is some opportunity to plan the actual use of force.

(19) Prone Restraint: The process of placing an individual "face-down" upon a surface and then securing or limiting the movement of the arms, legs, or trunk from that surface.

(20) Reactive Use of Force: The use of force in situations where time and circumstances do not permit approval by higher ranking employees, or consultation or planning.

(21) Reasonable Force: The use of physical force to achieve a legitimate correctional objective, where the type and amount of force are consistent with the situation and the objective to be achieved; and where alternatives to physical force are unavailable or ineffective; and where the force used is the minimum necessary to control the situation.

(22) Restraint Chair: A restraining device that allows for a person to sit upright in a chair that is designed to immobilize the person's arms and legs. In addition, the device provides for protection of the head for the person being restrained.

(23) Secure Custody: Custody exercised upon a person under the jurisdiction of the Department of Corrections by means of physical confinement within a facility of the Department of Corrections, or direct physical supervision of a person with or without use of restraints while outside a Department of Corrections facility.

(24) Security Equipment: Firearms, ammunition, batons, chemical agents, security restraints, electronic control devices, and similar devices.

(25) Security Restraints: Handcuffs, temporary cuffs, leg irons, belly chains, restraining chairs, and other similar equipment designed to restrict and control the person's movement from injuring himself/herself, others, and escape.

(25) Serious Physical Injury: Physical injury which creates a substantial risk of death or which causes serious and protracted disfigurement, protracted impairment of health, or protracted loss or impairment of the function of any bodily organ.

(27) Show of Force: A demonstration of the current ability to use force, such as the massing of officers or tactical squads.

(28) Stand Alone Minimum Security Facility: A minimum security facility that is not on the grounds of a medium or higher security facility.

(29) Specialty Impact Munitions: Munitions designed to incapacitate, distract, and control a subject with less likelihood of life threatening injury.

(30) Therapeutic Restraints: A type of restraint applied to an inmate for medical or mental health purposes, and designed to limit an inmate's movement. The kinds of restraints that may be used for therapeutic purposes include, but are not limited to, leather, rubber or canvas restraints for the arms, legs and upper torso.

(31) Use of Force: Any situation in which an employee uses physical force against an inmate or other person, except those situations in which security restraints are used in a standard manner for arrest, escort, or transport, or in which therapeutic restraints are used.

Stat. Auth.: ORS 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 423.020, 423.030 & 423.075
Hist.: CD 35-1978, f. 11-9-78, ef. 11-13-78; CD 7-1982(Temp), f. & ef. 1-29-82; CD 12-1982, f. & ef. 3-19-82; CD 3-1983, f. & ef. 1-20-83; CD 40-1985, f. & ef. 8-16-85; CD 42-1986, f. & ef. 10-17-86; CD 26-1987, f. & ef. 6-5-87; CD 12-1988, f. & cert. ef. 9-30-88; CD 21-1988(Temp), f. & cert. ef. 12-30-88; CD 9-1989, f. & cert. ef. 6-20-89; CD 20-1991, f. & cert. ef. 8-28-91; CD 3-1995, f. & cert. ef. 1-19-95; CD 20-1995, f. 10-26-95, cert. ef. 11-1-95; DOC 14-1998, f. & cert. ef. 6-18-98; DOC 3-2004(Temp), f. & cert. ef. 1-27-04 thru 7-25-04; Administrative correction 8-19-04; DOC 15-2004, f. & cert. ef. 11-2-04; DOC 19-2008, f. & cert. ef. 8-7-08; DOC 6-2013, f. & cert. ef. 6-21-13

291-013-0055
Applicability of the Rules

(1) All employees shall be thoroughly familiar with the departmental guidelines of this rule.

(2) Those employees whose duties require them to be in both institutional and community situations shall be thoroughly familiar with all sections of this rule. Parole and probation officers shall follow the department's rule on Use of Force (Community Corrections) (OAR 291-022) to provide guidance and direction in use of force incidents.

(3) If there is any question about specific equipment, procedures, etc., in a use of force situation, an employee shall be directed by the location of the situation, either in an institution or the community, rather than by distinctions concerning where he/she is duty stationed.

Stat. Auth.: ORS 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 423.020, 423.030 & 423.075
Hist.: CD 3-1995, f. & cert. ef. 1-19-95; DOC 14-1998, f. & cert. ef. 6-18-98; DOC 15-2004, f. & cert. ef. 11-2-04; DOC 6-2013, f. & cert. ef. 6-21-13

291-013-0070
Planned Use of Force

(1) The functional unit manager or designee will be contacted for authorization of the planned use of force involving firearms, batons, water hoses, electronic control devices, specialty impact munitions, and chemical agents other than aerosol sprays.

(2) Any planned use of force shall be carried out under the personal direction of supervisory or higher level staff, and only after consultation with and approval of the officer-in-charge. The officer-in-charge may be present when the use of force is employed if there is no anticipated danger of becoming a hostage.

(a) Chemical agents, electronic control device, baton, water force, or specialty impact munitions may be used prior to the arrival of the supervising employee if immediate use is essential to prevent and/or control death, serious injury, major disturbance or substantial destruction of property.

(b) If an employee is assaulted, he/she will not participate in a planned use of force, unless no other option is available; e.g., no other employees are readily available to participate in the planned use of force.

(3) A health care professional shall be contacted, if on duty at the facility, prior to the planned use of force to ensure medical assistance is readily available, if necessary, and to evaluate the inmate if he/she is medically high risk.

(4) If the inmate has a known history of mental health concerns, a mental health professional shall be contacted and consulted, if on duty at the facility, prior to the planned use of force to ensure mental health assistance is readily available, if necessary in accordance with DOC policy 40.1.14.

(5) Every planned use of force situation shall be videotaped provided that time and circumstances permit.

(a) The video recording should include a briefing, the use of force incident, and debriefing. The video recording should not be stopped during the use of force incident.

(b) The original video recording will be stored by the functional unit in accordance with the approved retention schedules from the date of the incident, or the time stored will be extended until the resolution of pending or actual litigation, or as otherwise directed by the department's legal counsel.

(c) A back-up video recording will be made and sent to the Office of the Inspector General. The Office of the Inspector General's will store the back-up tape in accordance with the approved retention schedule.

(d) Back-up tapes will be returned to the originating facility for disposition. A use of force video recording may be released with the approval of the functional unit manager or designee.

(6) The commander shall authorize the type and amount of force used during any declared emergency at a facility except for reactive use of force.

Stat. Auth.: ORS 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 423.020, 423.030 & 423.075
Hist.: CD 3-1995, f. & cert. ef. 1-19-95; CD 20-1995, f. 10-26-95, cert. ef. 11-1-95; DOC 14-1998, f. & cert. ef. 6-18-98, Renumbered from 291-013-0125; DOC 15-2004, f. & cert. ef. 11-2-04; DOC 19-2008, f. & cert. ef. 8-7-08; DOC 6-2013, f. & cert. ef. 6-21-13

291-013-0104
Security Equipment

(1) General Provisions:

(a) The Institutions Administrator will review all security equipment. The Director or designee shall approve all security equipment before it is issued and used as department authorized security equipment.

(b) Only department authorized and/or issued equipment shall be used to apply physical force to individuals.

(c) Security equipment shall not be issued to or used by an employee who has not been trained in the proper use of such devices.

(d) The above three sections (a)–(c) apply to all use of force incidents except for situations that require reactive use of force where there is a clear and imminent threat of death or great bodily injury, and where there is no other reasonable alternative.

(e) The storage and use of security equipment will be authorized by the Director through the appropriate functional unit manager.

(2) Security Restraints — General Use of Restraints:

(a) Security restraints are authorized to restrict, immobilize and control the movement of an inmate.

(b) The standard routine use of security restraints for escort or transportation of an inmate is not a use of force within the context of these rules. Situations in which an inmate has refused to be placed in security restraints, or has resisted after being placed in restraints are considered use of force within the context of these rules.

(3) Restricting Movement:

(a) Security restraints may be used to restrain an inmate with the express approval of the officer-in-charge, upon a demonstration that the inmate is out of control and engaged in behavior which, if unrestrained could:

(A) Result in significant destruction of property;

(B) Constitute a serious health or injury hazard to the inmate or others; or

(C) Escalate into a serious disturbance.

(b) Security restraints used to restrain an out-of-control inmate shall be terminated when the inmate has demonstrated behavior which would not result in the above three sections (A)–(C).

(c) Placing an inmate in security restraints or a restraint chair shall be considered a use of force within the context of these rules, except when placing an inmate in handcuffs/restraints for transportation or escort.

(d) Security restraints will not be placed around the neck or head, nor in any manner that restricts blood circulation or breathing.

(e) The hogtie method will not be used as a security restraint.

(f) Employees in general shall ensure that unnecessary pressure is not placed on the inmate's chest, back or neck while applying restraints. Employees shall maintain close observation of a restrained inmate in order to detect breathing difficulties and/or loss of consciousness.

(g) While using the prone restraint position when the correctional objective is met the inmate should be placed on his/her side or moved into a sitting position as soon as feasible. Employees will assess the inmate's physical condition.

(h) Restrained inmates will never be transported on their stomach.

(i) An employee shall check at least every 30 minutes and verify security restraints are not causing obvious injury or an obvious medical problem when an inmate has been placed in restraints as a result of a use of force situation. Each check of the restraints will be documented. A copy of the documentation shall accompany the unusual incident report.

(j) The officer-in-charge shall evaluate the need to restrain an out-of-control inmate every two hours with written documentation for the reason(s) to continue or discontinue security restraints or restraint chair. The documentation shall accompany the use-of-force review documentation.

(k) The officer-in-charge will notify a health care professional as soon as feasible, but not later than four hours from the application of security restraints or restraint chair.

(l) The health care professional, when notified, will perform the following:

(A) Evaluate the inmate's condition to verify the security restraints are not causing injury or an obvious medical problem;

(B) Evaluate the inmate's mental status and notify a qualified mental health professional, if necessary;

(C) Consider treatment or intervention as an alternative, or in conjunction with security restraints;

(D) Document the results of the evaluation; and

(E) Physically re-evaluate sections (A)–(D) above every two hours.

(m) Use of security restraints or restraint chair to restrain an out-of-control inmate will be documented and reported by the officer-in-charge to the functional unit manager or designee. The documentation shall accompany the use of force review documentation.

(n) Continued use of security restraints applied for a time period longer than eight hours, and every eight hours thereafter, shall require the written approval of the functional unit manager or designee in addition to the requirements of sections (j), (k), and (l) above.

(o) Continued use of the restraint chair for a time period longer than two hours, and every two hours thereafter, shall require the written or verbal approval of the functional unit manager or designee in addition to the requirements of sections (j), (k), and (l) above.

(p) Continued use of the restraint chair for a time period longer than two hours, and every two hours thereafter, during the transporting of an inmate shall require the verbal approval of the functional unit manager or designee.

(A) The officer-in-charge of the transport shall ensure that observation of the inmate is maintained and documented on the Trip Documentation Sheet every 30 minutes. The officer-in-charge shall ensure that the inmate is evaluated by a health care professional once the final destination is reached.

(B) Placing an inmate in the restraint chair shall be considered a use of force within the context of these rules, except when the restraint chair is being utilized as additional seating for inmates during transfers.

(q) Therapeutic Restraints: The documentation, application and use of therapeutic restraints will not be considered a use of force situation, but shall be in accordance with the department's rule on Therapeutic Restraints (OAR 291-071). Therapeutic restraints will be:

(A) Applied to an inmate only for medical or mental health treatment to limit the inmate's movement; and

(B) Applied to an inmate only upon the documented verbal or written order of a physician, except in the absence of a physician, a registered nurse may authorize the application of therapeutic restraints for a period not to exceed one hour.

(4) Chemical Agents, Electronic Control Devices, Batons, Water Force and Specialty Impact Munitions:

(a) The use of chemical agents other than aerosol spray, electronic control devices, batons, water force, and specialty impact munitions shall be authorized only by the functional unit manager or designee. The decision to use chemical agents, electronic control devices, batons, water force and specialty impact munitions shall be based on the level of force that, in the judgment of the functional unit manager or designee, is most likely to resolve the situation with the least amount of injury to all parties involved.

(b) The use of chemical agents, electronic control devices, batons, water force and specialty impact munitions may be used to subdue an inmate when the level of physical hands-on force required to subdue the inmate would potentially subject the employee, inmate or others to greater injury than would be incurred through the use of this security equipment.

(5) Use of Chemical Agents:

(a) The amount and type of chemical agent used and the means of dispersal shall be limited to that necessary to achieve the correctional objective and be used in accordance with the manufacturer's instructions and departmental training.

(b) Prior to the use of any chemical agent, and where time and circumstances permit, the inmate against whom it is directed shall be warned chemical agents will be used.

(c) If possible, a chemical agent shall not be used against an inmate known to suffer cardio-vascular, convulsive or respiratory ailments.

(d) An employee recently assaulted by an inmate shall not approve or apply chemical agents to the particular inmate, unless there is no reasonable alternative.

(e) An inmate shall not be restrained or held for the sole purpose of rendering him/her a more stationary target for a chemical agent. If chemical agents are administered to a handcuffed inmate, staff shall document the reason why the removal of the handcuffs was not feasible.

(f) Those affected by a chemical agent shall be permitted to wash their face, eyes and other exposed skin areas, as soon as possible after the chemical agent has been used.

(g) Those affected by a chemical agent in a closed area shall be permitted to move to an uncontaminated area as soon as possible after the chemical agent has been used.

(h) Clothing exposed to a chemical agent shall be removed as soon as feasible and clean clothing made immediately available.

(i) An employee(s) or inmate(s) affected by a chemical agent shall be examined by a health care professional as soon as feasible after the chemical agent has been used.

(j) An inmate(s) receiving an application of a chemical agent shall be under continuous staff observation for the first ten minutes.

(A) The inmate shall then be observed approximately every ten minutes for the first 30 minutes after receiving the application of a chemical agent.

(B) All observations shall be documented with a date and time reference.

(C) The documentation shall accompany the use of force review documentation.

(6) Use of Electronic Control Devices:

(a) Only agency approved electronic control devices shall be used.

(b) Medical Considerations:

(A) As soon as feasible following each use of an electronic control device, the inmate shall be afforded medical examination and treatment.

(B) An electronic control device shall not be deployed if there is knowledge that the inmate is pregnant.

(C) If the electronic control device utilizes probes that penetrate the skin, the probes shall be removed when the inmate is under control. Medical staff, if on duty at the facility, shall remove the probes. Trained security staff may remove the probes if medical staff are not available.

(D) If probes are embedded in soft tissue areas such as the head, neck, face and groin, removal shall be done by medical staff only.

(c) Electronic control devices will not be used in conjunction with aerosol propelled chemical agents.

(d) Prior to the deployment of an electronic control device, the supervisor and person assigned to be the operator shall have attended the approved departmental training on the operation and protocol associated with its use.

(7) Use of Specialty Impact Weapons:

(a) Specialty impact munitions are intended as a less lethal alternative to the use of deadly force. Use of specialty impact munitions shall be authorized by the functional unit manager or designee prior to deployment.

(b) After each use of specialty impact munitions, exposed inmates shall be examined by Health Services personnel.

(8) Firearms:

(a) The functional unit manager or designee will authorize the location and carrying of a department issued firearm on the grounds of a facility.

(b) A Transportation Unit officer or facility correctional officer may carry a firearm in the performance of his/her duties as authorized by the functional unit manager/designee and in accordance with the department policy.

(c) Prior to resorting to the use of firearms against an inmate or other persons, time and circumstances permitting, an employee shall first issue an appropriate warning to the inmate or other person in a readily understandable fashion. An appropriate warning may include, but is not limited to, one or more of the following:

(A) Shouting;

(B) Blowing a whistle;

(C) Hand signals; or

(D) Firing a warning shot.

(d) The discharge of a firearm will be handled in accordance with the departmental policy. The State Police or local law enforcement officials shall be notified to investigate any discharge of a firearm except for training or negligent discharge where injury or significant property damage has not occurred. The external law enforcement investigation shall be separate from the full review.

(e) Any employee involved in the discharge of a firearm in a situation on duty shall immediately report the incident to the officer-in-charge. The employee shall follow the department's policy on Critical Incident (40.1.8).

(f) A warning shot is the least preferred method of warning. It should be used only in situations where other warning methods are not practical or effective, and when there is a target that is sufficiently large to minimize the risk of harm to others from a missed shot or ricochet.

(g) Time and circumstances permitting, an employee shall attempt to warn an inmate that is observed to be:

(A) Entering or inside a restricted security perimeter zone;

(B) Tampering with or cutting security perimeter equipment or fence/wall;

(C) On or climbing a security fence/wall;

(D) Moving toward any motor vehicle or airborne craft in an obvious attempt to escape;

(E) Engaged in any other behavior that is a clear or obvious attempt to escape; or

(F) Engaged in any behavior that poses serious bodily injury or death to oneself or another person.

Stat. Auth.: ORS 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 423.020, 423.030 & 423.075
Hist.: DOC 14-1998, f. & cert. ef. 6-18-98; Renumbered from 291-013-0090, DOC 15-2004, f. & cert. ef. 11-2-04; DOC 14-2005, f. 10-14-05, cert. ef. 10-24-05; DOC 19-2008, f. & cert. ef. 8-7-08; DOC 6-2013, f. & cert. ef. 6-21-13

291-013-0110
Bloodborne Pathogens

When a person has been exposed to blood or body fluid resulting from the use of force, standard universal precautions shall be implemented as described in the department's policy on Bloodborne Pathogens (20.6.7).

Stat. Auth.: ORS 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 423.020, 423.030 & 423.075
Hist.: CD 3-1995, f. & cert. ef. 1-19-95; DOC 14-1998, f. & cert. ef. 6-18-98, Renumbered from 291-013-0075; DOC 19-2008, f. & cert. ef. 8-7-08; DOC 6-2013, f. & cert. ef. 6-21-13

291-013-0130
Notifications

(1) Whenever force is used, a detailed written report shall be prepared. The Unusual Incident Report (CD 115) will be used as the primary document to report all use of force situations.

(2) All employees witnessing or directly involved in a use of force incident shall individually prepare and submit a written memorandum describing their involvement and observation regarding the incident. The memorandum will be attached to the Unusual Incident Report (CD 115).

(3) A Use of Force — Preliminary Review Summary (CD 1346) will accompany the Unusual Incident Report.

(4) Supervisory notification and authorization will be obtained prior to a planned use of force.

(5) The appropriate supervisor shall be notified by the involved employee(s) as soon as possible following a reactive use of force. The functional unit manager or designee will be notified immediately following any use of force incident.

(6) The Unusual Incident Report will be forwarded to the appropriate Institutions Administrator within five working days of the incident.

Stat. Auth.: ORS 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 423.020, 423.030 & 423.075
Hist.: CD 3-1995, f. & cert. ef. 1-19-95; DOC 14-1998, f. & cert. ef. 6-18-98, Renumbered from 291-013-0095; DOC 15-2004, f. & cert. ef. 11-2-04; DOC 6-2013, f. & cert. ef. 6-21-13

291-013-0140
Reviews

(1) General:

(a) Whenever staff employs force in response to an incident involving an inmate, a preliminary review of the use of force incident shall be conducted in accordance with the procedures established in these rules.

(b) A full review of a use of force incident shall be conducted by independent departmental review in accordance with the procedures established in these rules when requested by the Inspector General, or when the following circumstances exist:

(A) A person received a serious physical injury in the course of the use of force incident; or

(B) A firearm was discharged during the incident, as defined in the firearms section of OAR 291-013-0105.

(c) The Inspector General may decide if the full review process for the incident requires assembly of a departmental review team to conduct the full review, or order a separate investigation be conducted by a special investigator from the Investigations Unit.

(2) Preliminary Review:

(a) The officer-in-charge shall conduct a preliminary review of all use of force incidents within 48 hours of the incident.

(b) Staff involved in the use of force incident shall prepare, assemble and provide to the officer-in-charge all information and records that are relevant to the incident, including but not limited to reports, documents, videos, and photographs of involved persons and witnesses. Staff and/or inmates may be interviewed as necessary to clarify or obtain relevant information. The officer-in-charge shall review the information and records to ensure the documentation of the incident is complete.

(c) The officer-in-charge shall review the documentation for compliance with administrative directives and prepare a preliminary review report. The officer-in-charge shall forward the preliminary review report

and supporting documentation to the Assistant Superintendent of Security/security manager, with one of the following recommendations:

(A) In compliance with administrative directives, requires only a preliminary review; and

(i) No further action is required; or

(ii) Further corrective action is required by the functional unit manager or designee to address perceived training, security, or other operational issues;

(B) In compliance with administrative directives, but requires a full review; or

(C) Not in compliance with administrative directives, but requires only a preliminary review because appropriate corrective action has been taken by the functional unit manager or designee; or

(D) Not in compliance with administrative directives, and requires a full review.

(d) The Assistant Superintendent of Security/security manager shall review the preliminary review report and all supporting documentation and make any necessary modification or additions he/she deems necessary. The review shall include a preliminary review of the video footage and all associated reports. The preliminary review report and supporting documentation shall be forwarded to the functional unit manager.

(e) The functional unit manager shall review the preliminary review report and all supporting documentation and make any necessary modification or additions he/she deems necessary. The review shall include a preliminary review of the video footage and all associated reports. The functional unit manager shall document all corrective action taken. If the functional unit manager notes signs of excessive force, he/she shall notify the appropriate Institutions Administrator directly and provide necessary documents, so that there is no undue delay in initiating a full review or separate investigation. The functional unit manager shall make his/her recommendation on the preliminary review and forward the preliminary review and supporting documentation to the Institutions Administrator.

(f) The Institutions Administrator shall review the preliminary review report and supporting documentation. The Institutions Administrator may determine no further review is required. If the Institutions Administrator determines a full review is warranted, all relevant information will be forwarded to the Inspector General or designee for further review.

(g) All preliminary review reports and supporting documentation will be forwarded the Office of Inspector General for record retention.

(3) Full Review:

(a) When a full review of a use of force incident is requested by the Institutions Administrator and approved by the Inspector General or otherwise required under these rules, a departmental review team shall be assembled to conduct the full review, or a separate investigation shall be conducted by a special investigator from the Investigations Unit.

(b) The departmental review team shall include, at a minimum, a representative from Special Investigations assigned by the Inspector General and a representative from two separate functional units other than the functional unit in which the incident took place. The functional unit representatives may include a represented employee. The Special Investigations representative shall chair the review team and arrange for the appointment of the review team members in consultation with the functional unit managers.

(c) The departmental review team shall review the final preliminary review report and all supporting documentation for compliance with administrative directives.

(d) If any member of the review team deems it necessary or advisable to have additional staff or inmate interviews conducted, the review team chair shall arrange for an Investigations Unit employee(s) to conduct the interview(s).

(e) If the review team chair determines that a crime may have been committed in the course of the use of force incident, he/she shall contact the State Police or local law enforcement officials before arranging for any additional interview(s), to determine if the law enforcement officials are conducting a criminal investigation regarding the incident, and if so, whether the additional interview(s) would interfere with the investigation.

(f) If advised that the interview(s) would interfere with a pending criminal investigation, the interview(s) shall be postponed until the criminal investigation has been concluded.

(g) Evaluation Report:

(A) After completing the review process, the review team shall prepare and submit its evaluation report to the Inspector General within 30 working days following completion of the full review.

(B) The report shall set forth the departmental review team's determination whether the actions taken were in compliance with Department of Corrections administrative directive(s).

(C) If the review team finds evidence of noncompliance, it shall specify these findings and the rationale upon which the findings have been based in its report.

(D) The Inspector General shall review the report for completeness and forward it to the functional unit manager, appropriate Institutions Administrator, and Assistant Director of Operations for review and any necessary action.

Stat. Auth.: ORS 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 423.020, 423.030 & 423.075
Hist.: CD 3-1995, f. & cert. ef. 1-19-95; CD 20-1995, f. 10-26-95, cert. ef. 11-1-95; DOC 14-1998, f. & cert. ef. 6-18-98, Renumbered from 291-013-0105; DOC 15-2004, f. & cert. ef. 11-2-04; DOC 6-2013, f. & cert. ef. 6-21-13

291-013-0206
Electronic Control Devices

(1) Only agency approved electronic control devices shall be used.

(2) Use of an electronic restraint device for court appearances or transportation will be approved by the functional unit manager or designee.

(3) Medical Considerations:

(a) As soon as feasible following each use of an electronic control device, the inmate shall be afforded medical examination and treatment.

(b) An electronic control device shall not be deployed if there is knowledge that the inmate is pregnant.

(c) If the electronic control device utilizes probes that penetrate the skin, they shall be removed when the inmate is under control. If available, medical staff shall remove the probes. Trained security staff may remove the probes if medical staff are not available.

(d) If probes are embedded in soft tissue areas such as the head, neck, face and groin removal shall be done by medical staff only.

(4) Electronic control devices will not be used in conjunction with aerosol propelled chemical agents.

Stat. Auth.: ORS 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 423.020, 423.030 & 423.075
Hist.: DOC 15-2004, f. & cert. ef. 11-2-04; DOC 19-2008, f. & cert. ef. 8-7-08; DOC 6-2013, f. & cert. ef. 6-21-13

291-013-0215
Lethal Force

(1) Employees shall consider every reasonable means of control before resorting to the use of lethal force.

(2) Use of Lethal Force During Transporting of Inmates: An employee may use lethal force when transporting an inmate(s) to the extent that an employee reasonably believes it necessary to:

(a) Prevent imminent serious bodily injury or death to the employee or another person.

(b) Prevent the escape of an inmate classified as custody Level 3 or higher, of if the inmate is classified as custody Level 1 and 2 and is being transported with another inmate(s) who has been classified as custody Level 3 or higher.

(3) Use of Lethal Force When Supervising Custody Level 1 and 2 Inmates Engaged in Work Crews or Other Approved Activities in the Community: Supervisors of custody Level 1 and 2 inmates engaged in work crews or other authorized activities in the community are not authorized to use lethal force to prevent an escape. Lethal force may be used to prevent imminent serious bodily injury or death to the supervisor or another person.

(4) Prior to resorting to the use of lethal force against an inmate or other person, if feasible, the employee shall give a verbal warning from the imminent use of lethal force.

(5) A warning shot will not be used in the community before the use of lethal force. Other practical warning methods will be used, if time and circumstances permit, before using lethal force.

(6) Firearms will not be fired at or from a moving vehicle or airborne craft, except in self defense or defense of another from the imminent use of lethal force.

(7) Firearms will not be used if innocent people are in the line of fire.

Stat. Auth.: ORS 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 423.020, 423.030 & 423.075
Hist.: CD 3-1995, f. & cert. ef. 1-19-95; DOC 14-1998, f. & cert. ef. 6-18-98; DOC 3-2004(Temp), f. & cert. ef. 1-27-04 thru 7-25-04; Administrative correction 8-19-04; DOC 15-2004, f. & cert. ef. 11-2-04; DOC 19-2008, f. & cert. ef. 8-7-08; DOC 6-2013, f. & cert. ef. 6-21-13

Department of Energy
Chapter 330

Rule Caption: Clarifies eligible uses of loan proceeds from the Small Scale Energy Loan program.
Adm. Order No.: DOE 2-2013(Temp)
Filed with Sec. of State: 6-17-2013
Certified to be Effective: 6-17-13 thru 12-13-13
Notice Publication Date:
Rules Amended: 330-110-0040
Subject: The temporary rule for the Small Scale Energy Loan program (SELP) clarifies eligible uses of loan proceeds. In December 2012, the Oregon Department of Energy filed permanent rules amending OAR 330-110-0040(9) incorrectly. The Oregon Department of Energy believes a temporary rule is justified because without a temporary rule, a borrower could attempt to obtain a SELP loan for a single item, rather than a group of items that makeup a SELP project. The consequences of the rule as written, creates confusion about the allowable uses of bond funds as regulated by federal law. By adopting this temporary rule, clarifying eligible uses of loan proceeds, the Oregon Department of Energy will be able mitigate confusion and align with federal law.
Rules Coordinator: Kathy Stuttaford—(503) 373-2127

330-110-0040
Loan Limits, Security, and Conditions

(1) The Director may limit the term and amount of any loan or loan approval. The Director may deny any application or set such terms and conditions in regard to any loan or loan approval as needed to assure a sound loan or to protect the fiscal integrity of the program.

(2) A loan secured by real property must be secured by a first lien on such real property in favor of the State of Oregon and must not exceed eighty percent of the security value of such real property. The real property that is collateral for the loan must have been appraised by a licensed appraiser, county assessor or Department appraiser, at the discretion of the director, no longer than six months prior to the date of the loan approval. The Department will consider junior liens only on a case-by-case basis.

(3) If a loan to a municipal corporation will be repaid from project income, the security package for the loan may include the project income.

(4) A loan to a state agency, an eligible federal agency or a public corporation may be secured by project income, in addition to the facility or equipment that make up the project, by a lease purchase contract or by other income or security in accordance with ORS 470.170. State agencies, eligible federal agencies or public corporation borrowers must provide resolutions or other official action of borrower's governing body approving the loan and the other matters contemplated by the loan documents, and of all other documents evidencing any other necessary action by Applicant's governing body.

(5) The Department generally requires an unconditional and absolute guaranty of the owners or the principal shareholder of the borrower or that of a person having sufficient resources to satisfy the borrower's repayment obligation for the loan should the borrower default.

(6) The Director may consider savings in operation and maintenance costs in estimating the annual project cost savings. The Director may also, when calculating the estimated savings in fuel costs, consider reasonably expected increases in the cost of fuel.

(7) A project that primarily produces energy for sale must have:

(a) Secure sources of supply and contracts for the sale of output;

(b) Projected income, net of operating expenses and maintenance costs, of at least 125 percent of annual debt service for each year of the loan; and

(c) An identified secondary source of repayment apart from the project income.

(8) Unless the Director finds that mitigating financial factors warrant otherwise, a loan to a business for a project that saves or produces energy for use on site, is an alternative fuel project or is an energy-saving recycling project may be made only:

(a) Upon an identifiable and reasonable primary repayment source and the pledge of adequate security;

(b) For less than 80 percent of the security value of real property on which the Department has a first lien, the Department will consider junior liens on a case-by-case basis;

(c) To a business that has made a profit after taxes for at least the two years immediately preceding the loan application; and

(d) To a business that has a ratio of current assets to current liabilities of at least 1.75 to 1 and a ratio of total debt to owner's equity of no more than 2 to 1. The Director may exempt a business from the requirements of OAR 330-110-0040 if it demonstrates to the satisfaction of the Director that sound businesses of similar type and size do not normally meet these standards.

(9) Loan proceeds must be used for the costs of a small scale local energy project, with the following limitations:

(a) Cost of acquisition of the project site must not exceed ten percent of the loan amount.

(b) Capital for start-up must not exceed three percent of the loan amount.

(c) Reserves must not exceed fifteen percent of the loan amount.

(10) The loan proceeds of an alternative fuel project may only be used for the following purposes:

(a) Incremental costs of the project that are beyond the reasonable estimated minimum costs to construct or install a similar project without alternative fuel features. Incremental costs do not include the cost of equipment or devices that, in standard industry practice, are used to dispense gasoline or, in the case of vehicles, equipment or devices that use gasoline and that also allow use of an alternative fuel without modification. Alternative fueling stations with underground fuel tanks do not qualify for funding as alternative fuel projects.

(b) In the case of vehicles, products and installation of such products approved by and meeting or exceeding the emission standards of the Department of Environmental Quality.

(11) No more than fifty percent of loan proceeds may be used to refinance existing debt authorized by ORS 470.050(27)(g) unless such debt is with the Department. The refinancing must result in a significant increase in the security value of the loan security.

Stat. Auth.: ORS 469 & 470.140
Stats. Implemented: ORS 470.080, 470.120, 470.150 - 470.155, 470.170 & 470.210
Hist.: DOE 12-1980, f. & ef. 12-16-80; DOE 6-1982, f. & ef. 4-21-82; DOE 2-1983, f. & ef. 5-16-83; DOE 3-1983(Temp), f. & ef. 9-20-83; DOE 4-1984, f. & ef. 3-6-84; DOE 2-1986, f. & ef. 3-4-86; DOE 4-1988, f. & cert. ef. 7-26-88; DOE 1-1993, f. & cert. ef. 1-27-93; DOE 1-1994, f. & cert. ef. 4-1-94; DOE 2-1998, f. & cert. ef. 9-30-98; DOE 7-2004, f. & cert. ef. 12-20-04; DOE 13-2012, f. & cert. ef. 12-20-12; DOE 2-2013(Temp), f. & cert. ef. 6-17-13 thru 12-13-13

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Department of Environmental Quality
Chapter 340

Rule Caption: Corrections and Clarifications to Nonpoint Source Regulations
Adm. Order No.: DEQ 5-2013
Filed with Sec. of State: 6-21-2013
Certified to be Effective: 6-21-13
Notice Publication Date: 3-1-2013
Rules Adopted: 340-041-0007, 340-041-0028, 340-041-0061
Subject: To meet obligations under a stipulated order and legal agreement, DEQ proposes changes to water quality standards for nonpoint sources. The proposed amendments to water quality standards do not change the way agricultural and forest land management activities are regulated to meet water quality standards, or the statutory relationships between DEQ and the Oregon Departments of Agriculture and Forestry. Proposed amendments would also remain consistent with the original intent of federal and state regulations. DEQ proposes deleting the following provisions that describe how nonpoint sources comply with water quality standards:

1. Statewide Narrative Criteria — OAR 340-041-0007(5)

The proposed amendment would remove the description of how logging and forest management activities are subject to water quality standards and load allocations. The amendment would honor a legal agreement signed Jan. 31, 2013.

2. Temperature Rule — OAR 340-041-0028(12)

Proposed amendments would remove portions of the rule that describe how:

- Nonpoint sources would implement water quality standards for temperature on private, state and federal agricultural lands and forests, and

- Nonpoint sources, except forestry and agriculture that comply with their temperature management plans, are considered in compliance with the temperature rule.

3. Other implementation of water quality criteria — OAR 340-041-0061 The proposed amendments would remove portions of the rule that describe how nonpoint sources would implement water quality standards on private, state and federal agricultural lands and forests.

Rules Coordinator: Maggie Vandehey—(503) 229-6878

340-041-0007
Statewide Narrative Criteria

(1) Notwithstanding the water quality standards contained in this Division, the highest and best practicable treatment and/or control of wastes, activities, and flows must in every case be provided so as to maintain dissolved oxygen and overall water quality at the highest possible levels and water temperatures, coliform bacteria concentrations, dissolved chemical substances, toxic materials, radioactivity, turbidities, color, odor, and other deleterious factors at the lowest possible levels.

(2) Where a less stringent natural condition of a water of the State exceeds the numeric criteria set out in this Division, the natural condition supersedes the numeric criteria and becomes the standard for that water body. However, there are special restrictions, described in OAR 340-041-0004(9)(a)(D)(iii), that may apply to discharges that affect dissolved oxygen.

(3) For any new waste sources, alternatives that utilize reuse or disposal with no discharge to public waters must be given highest priority for use wherever practicable. New source discharges may be approved subject to the criteria in OAR 340-041-0004(9).

(4) No discharges of wastes to lakes or reservoirs may be allowed except as provided in section OAR 340-041-0004(9).

(5) Log handling in public waters must conform to current Commission policies and guidelines.

(6) Sand and gravel removal operations must be conducted pursuant to a permit from the Division of State Lands and separated from the active flowing stream by a watertight berm wherever physically practicable. Recirculation and reuse of process water must be required wherever practicable. Discharges or seepage or leakage losses to public waters may not cause a violation of water quality standards or adversely affect legitimate beneficial uses.

(7) Road building and maintenance activities must be conducted in a manner so as to keep waste materials out of public waters and minimize erosion of cut banks, fills, and road surfaces.

(8) In order to improve controls over nonpoint sources of pollution, federal, State, and local resource management agencies will be encouraged and assisted to coordinate planning and implementation of programs to regulate or control runoff, erosion, turbidity, stream temperature, stream flow, and the withdrawal and use of irrigation water on a basin-wide approach so as to protect the quality and beneficial uses of water and related resources. Such programs may include, but not be limited to, the following:

(a) Development of projects for storage and release of suitable quality waters to augment low stream flow;

(b) Urban runoff control to reduce erosion;

(c) Possible modification of irrigation practices to reduce or minimize adverse impacts from irrigation return flows;

(d) Stream bank erosion reduction projects; and

(e) Federal water quality restoration plans.

(9) The development of fungi or other growths having a deleterious effect on stream bottoms, fish or other aquatic life, or that are injurious to health, recreation, or industry may not be allowed;

(10) The creation of tastes or odors or toxic or other conditions that are deleterious to fish or other aquatic life or affect the potability of drinking water or the palatability of fish or shellfish may not be allowed;

(11) The formation of appreciable bottom or sludge deposits or the formation of any organic or inorganic deposits deleterious to fish or other aquatic life or injurious to public health, recreation, or industry may not be allowed;

(12) Objectionable discoloration, scum, oily sheens, or floating solids, or coating of aquatic life with oil films may not be allowed;

(13) Aesthetic conditions offensive to the human senses of sight, taste, smell, or touch may not be allowed;

(14) Radioisotope concentrations may not exceed maximum permissible concentrations (MPC's) in drinking water, edible fishes or shellfishes, wildlife, irrigated crops, livestock and dairy products, or pose an external radiation hazard;

(15) Minimum Design Criteria for Treatment and Control of Wastes. Except as provided in OAR 340-041-0101 through 340-041-0350, and subject to the implementation requirements set forth in OAR 340-041-0061, prior to discharge of any wastes from any new or modified facility to any waters of the State, such wastes must be treated and controlled in facilities designed in accordance with the following minimum criteria.

(a) In designing treatment facilities, average conditions and a normal range of variability are generally used in establishing design criteria. A facility once completed and placed in operation should operate at or near the design limit most of the time but may operate below the design criteria limit at times due to variables which are unpredictable or uncontrollable. This is particularly true for biological treatment facilities. The actual operating limits are intended to be established by permit pursuant to ORS 468.740 and recognize that the actual performance level may at times be less than the design criteria.

(A) Sewage wastes:

(i) Effluent BOD concentrations in mg/l, divided by the dilution factor (ratio of receiving stream flow to effluent flow) may not exceed one unless otherwise approved by the Commission;

(ii) Sewage wastes must be disinfected, after treatment, equivalent to thorough mixing with sufficient chlorine to provide a residual of at least 1 part per million after 60 minutes of contact time unless otherwise specifically authorized by permit;

(iii) Positive protection must be provided to prevent bypassing raw or inadequately treated sewage to public waters unless otherwise approved by the Department where elimination of inflow and infiltration would be necessary but not presently practicable; and

(iv) More stringent waste treatment and control requirements may be imposed where special conditions make such action appropriate.

(B) Industrial wastes:

(i) After maximum practicable in-plant control, a minimum of secondary treatment or equivalent control (reduction of suspended solids and organic material where present in significant quantities, effective disinfection where bacterial organisms of public health significance are present, and control of toxic or other deleterious substances);

(ii) Specific industrial waste treatment requirements may be determined on an individual basis in accordance with the provisions of this plan, applicable federal requirements, and the following:

(I) The uses that are or may likely be made of the receiving stream;

(II) The size and nature of flow of the receiving stream;

(III) The quantity and quality of wastes to be treated; and

(IV) The presence or absence of other sources of pollution on the same watershed.

(iii) Where industrial, commercial, or agricultural effluents contain significant quantities of potentially toxic elements, treatment requirements may be determined utilizing appropriate bioassays;

(iv) Industrial cooling waters containing significant heat loads must be subjected to off-stream cooling or heat recovery prior to discharge to public waters;

(v) Positive protection must be provided to prevent bypassing of raw or inadequately treated industrial wastes to any public waters;

(vi) Facilities must be provided to prevent and contain spills of potentially toxic or hazardous materials.

Stat. Auth.: ORS 468.020, 468B.030, 468B.035, 468B.048
Stats. Implemented: ORS 468B.030, 468B.035, 468B.048
Hist.: DEQ 17-2003, f. & cert. ef. 12-9-03; DEQ 2-2007, f. & cert. ef. 3-15-07; DEQ 10-2011, f. & cert. ef. 7-13-11; DEQ 5-2013, f. & cert. ef. 6-21-13

340-041-0028
Temperature

(1) Background. Water temperatures affect the biological cycles of aquatic species and are a critical factor in maintaining and restoring healthy salmonid populations throughout the State. Water temperatures are influenced by solar radiation, stream shade, ambient air temperatures, channel morphology, groundwater inflows, and stream velocity, volume, and flow. Surface water temperatures may also be warmed by anthropogenic activities such as discharging heated water, changing stream width or depth, reducing stream shading, and water withdrawals.

(2) Policy. It is the policy of the Commission to protect aquatic ecosystems from adverse warming and cooling caused by anthropogenic activities. The Commission intends to minimize the risk to cold-water aquatic ecosystems from anthropogenic warming, to encourage the restoration and protection of critical aquatic habitat, and to control extremes in temperature fluctuations due to anthropogenic activities. The Commission recognizes that some of the State's waters will, in their natural condition, not provide optimal thermal conditions at all places and at all times that salmonid use occurs. Therefore, it is especially important to minimize additional warming due to anthropogenic sources. In addition, the Commission acknowledges that control technologies, best management practices and

other measures to reduce anthropogenic warming are evolving and that the implementation to meet these criteria will be an iterative process. Finally, the Commission notes that it will reconsider beneficial use designations in the event that man-made obstructions or barriers to anadromous fish passage are removed and may justify a change to the beneficial use for that water body.

(3) Purpose. The purpose of the temperature criteria in this rule is to protect designated temperature-sensitive, beneficial uses, including specific salmonid life cycle stages in waters of the State.

(4) Biologically Based Numeric Criteria. Unless superseded by the natural conditions criteria described in section (8) of this rule, or by subsequently adopted site-specific criteria approved by EPA, the temperature criteria for State waters supporting salmonid fishes are as follows:

(a) The seven-day-average maximum temperature of a stream identified as having salmon and steelhead spawning use on subbasin maps and tables set out in OAR 340-041-0101 to 340-041-0340: Tables 101B, and 121B, and Figures 130B, 151B, 160B, 170B, 220B, 230B, 271B, 286B, 300B, 310B, 320B, and 340B, may not exceed 13.0 degrees Celsius (55.4 degrees Fahrenheit) at the times indicated on these maps and tables;

(b) The seven-day-average maximum temperature of a stream identified as having core cold water habitat use on subbasin maps set out in OAR 340-041-101 to 340-041-340: Figures 130A, 151A, 160A, 170A, 180A, 201A, 220A, 230A, 271A, 286A, 300A, 310A, 320A, and 340A, may not exceed 16.0 degrees Celsius (60.8 degrees Fahrenheit);

(c) The seven-day-average maximum temperature of a stream identified as having salmon and trout rearing and migration use on subbasin maps set out at OAR 340-041-0101 to 340-041-0340: Figures 130A, 151A, 160A, 170A, 220A, 230A, 271A, 286A, 300A, 310A, 320A, and 340A, may not exceed 18.0 degrees Celsius (64.4 degrees Fahrenheit);

(d) The seven-day-average maximum temperature of a stream identified as having a migration corridor use on subbasin maps and tables OAR 340-041-0101 to 340-041-0340: Tables 101B, and 121B, and Figures 151A, 170A, 300A, and 340A, may not exceed 20.0 degrees Celsius (68.0 degrees Fahrenheit). In addition, these water bodies must have coldwater refugia that are sufficiently distributed so as to allow salmon and steelhead migration without significant adverse effects from higher water temperatures elsewhere in the water body. Finally, the seasonal thermal pattern in Columbia and Snake Rivers must reflect the natural seasonal thermal pattern;

(e) The seven-day-average maximum temperature of a stream identified as having Lahontan cutthroat trout or redband trout use on subbasin maps and tables set out in OAR 340-041-0101 to 340-041-0340: Tables 121B, 140B, 190B, and 250B, and Figures 180A, 201A, 260A and 310A may not exceed 20.0 degrees Celsius (68.0 degrees Fahrenheit);

(f) The seven-day-average maximum temperature of a stream identified as having bull trout spawning and juvenile rearing use on subbasin maps set out at OAR 340-041-0101 to 340-041-0340: Figures 130B, 151B, 160B, 170B, 180A, 201A, 260A, 310B, and 340B, may not exceed 12.0 degrees Celsius (53.6 degrees Fahrenheit). From August 15 through May 15, in bull trout spawning waters below Clear Creek and Mehlhorn reservoirs on Upper Clear Creek (Pine Subbasin), below Laurance Lake on the Middle Fork Hood River, and below Carmen reservoir on the Upper McKenzie River, there may be no more than a 0.3 degrees Celsius (0.5 Fahrenheit) increase between the water temperature immediately upstream of the reservoir and the water temperature immediately downstream of the spillway when the ambient seven-day-average maximum stream temperature is 9.0 degrees Celsius (48 degrees Fahrenheit) or greater, and no more than a 1.0 degree Celsius (1.8 degrees Fahrenheit) increase when the seven-day-average stream temperature is less than 9 degrees Celsius.

(5) Unidentified Tributaries. For waters that are not identified on the "Fish Use Designations" maps referenced in section (4) of this rule, the applicable criteria for these waters are the same criteria as is applicable to the nearest downstream water body depicted on the applicable map. This section (5) does not apply to the "Salmon and Steelhead Spawning Use Designations" maps.

(6) Natural Lakes. Natural lakes may not be warmed by more than 0.3 degrees Celsius (0.5 degrees Fahrenheit) above the natural condition unless a greater increase would not reasonably be expected to adversely affect fish or other aquatic life. Absent a discharge or human modification that would reasonably be expected to increase temperature, DEQ will presume that the ambient temperature of a natural lake is the same as its natural thermal condition.

(7) Oceans and Bays. Except for the Columbia River above river mile 7, ocean and bay waters may not be warmed by more than 0.3 degrees Celsius (0.5 degrees Fahrenheit) above the natural condition unless a greater increase would not reasonably be expected to adversely affect fish or other aquatic life. Absent a discharge or human modification that would reasonably be expected to increase temperature, DEQ will presume that the ambient temperature of the ocean or bay is the same as its natural thermal condition.

(8) Natural Conditions Criteria. Where the department determines that the natural thermal potential of all or a portion of a water body exceeds the biologically-based criteria in section (4) of this rule, the natural thermal potential temperatures supersede the biologically-based criteria, and are deemed to be the applicable temperature criteria for that water body.

(9) Cool Water Species.

(a) No increase in temperature is allowed that would reasonably be expected to impair cool water species. Waters of the State that support cool water species are identified on subbasin tables and figures set out in OAR 340-041-0101 to 340-041-0340; Tables 140B, 190B and 250B, and Figures 180A, 201A and 340A.

(b) See OAR 340-041-0185 for a basin specific criterion for the Klamath River.

(10) Borax Lake Chub. State waters in the Malheur Lake Basin supporting the Borax Lake chub may not be cooled more than 0.3 degrees Celsius (0.5 degrees Fahrenheit) below the natural condition.

(11) Protecting Cold Water.

(a) Except as described in subsection (c) of this rule, waters of the State that have summer seven-day-average maximum ambient temperatures that are colder than the biologically based criteria in section (4) of this rule, may not be warmed by more than 0.3 degrees Celsius (0.5 degrees Fahrenheit) above the colder water ambient temperature. This provision applies to all sources taken together at the point of maximum impact where salmon, steelhead or bull trout are present.

(b) A point source that discharges into or above salmon & steelhead spawning waters that are colder than the spawning criterion, may not cause the water temperature in the spawning reach where the physical habitat for spawning exists during the time spawning through emergence use occurs, to increase more than the following amounts after complete mixing of the effluent with the river:

(A) If the rolling 60 day average maximum ambient water temperature, between the dates of spawning use as designated under subsection (4)(a) of this rule, is 10 to 12.8 degrees Celsius, the allowable increase is 0.5 Celsius above the 60 day average; or

(B) If the rolling 60 day average maximum ambient water temperature, between the dates of spawning use as designated under subsection (4)(a) of this rule, is less than 10 degrees Celsius, the allowable increase is 1.0 Celsius above the 60 day average, unless the source provides analysis showing that a greater increase will not significantly impact the survival of salmon or steelhead eggs or the timing of salmon or steelhead fry emergence from the gravels in downstream spawning reach.

(c) The cold water protection narrative criteria in subsection (a) do not apply if:

(A) There are no threatened or endangered salmonids currently inhabiting the water body;

(B) The water body has not been designated as critical habitat; and

(C) The colder water is not necessary to ensure that downstream temperatures achieve and maintain compliance with the applicable temperature criteria.

(12) Implementation of the Temperature Criteria.

(a) Minimum Duties. There is no duty for anthropogenic sources to reduce heating of the waters of the State below their natural condition. Similarly, each anthropogenic point and nonpoint source is responsible only for controlling the thermal effects of its own discharge or activity in accordance with its overall heat contribution. In no case may a source cause more warming than that allowed by the human use allowance provided in subsection (b) of this rule.

(b) Human Use Allowance. Insignificant additions of heat are authorized in waters that exceed the applicable temperature criteria as follows:

(A) Prior to the completion of a temperature TMDL or other cumulative effects analysis, no single NPDES point source that discharges into a temperature water quality limited water may cause the temperature of the water body to increase more than 0.3 degrees Celsius (0.5 Fahrenheit) above the applicable criteria after mixing with either twenty five (25) percent of the stream flow, or the temperature mixing zone, whichever is more restrictive; or

(B) Following a temperature TMDL or other cumulative effects analysis, waste load and load allocations will restrict all NPDES point sources and nonpoint sources to a cumulative increase of no greater than

0.3 degrees Celsius (0.5 Fahrenheit) above the applicable criteria after complete mixing in the water body, and at the point of maximum impact.

(C) Point sources must be in compliance with the additional mixing zone requirements set out in OAR 340-041-0053(2)(d).

(D) A point source in compliance with the temperature conditions of its NPDES permit is deemed in compliance with the applicable criteria.

(c) Air Temperature Exclusion. A water body that only exceeds the criteria set out in this rule when the exceedance is attributed to daily maximum air temperatures that exceed the 90th percentile value of annual maximum seven-day average maximum air temperatures calculated using at least 10 years of air temperature data, will not be listed on the section 303(d) list of impaired waters and sources will not be considered in violation of this rule.

(d) Low Flow Conditions. An exceedance of the biologically-based numeric criteria in section (4) of this rule, or an exceedance of the natural condition criteria in section (8) of this rule will not be considered a permit violation during stream flows that are less than the 7Q10 low flow condition for that water body.

(e) Other Nonpoint Sources. The department may, on a case-by-case basis, require nonpoint sources (other than forestry and agriculture), including private hydropower facilities regulated by a 401 water quality certification, that may contribute to warming of State waters beyond 0.3 degrees Celsius (0.5 degrees Fahrenheit), and are therefore designated as water-quality limited, to develop and implement a temperature management plan to achieve compliance with applicable temperature criteria or an applicable load allocation in a TMDL pursuant to OAR 340-042-0080.

(A) Each plan must ensure that the nonpoint source controls its heat load contribution to water temperatures such that the water body experiences no more than a 0.3 degrees Celsius (0.5 degree Fahrenheit) increase above the applicable criteria from all sources taken together at the maximum point of impact.

(B) Each plan must include a description of best management practices, measures, effluent trading, and control technologies (including eliminating the heat impact on the stream) that the nonpoint source intends to use to reduce its temperature effect, a monitoring plan, and a compliance schedule for undertaking each measure.

(C) The Department may periodically require a nonpoint source to revise its temperature management plan to ensure that all practical steps have been taken to mitigate or eliminate the temperature effect of the source on the water body.

(f) Compliance Methods. Anthropogenic sources may engage in thermal water quality trading in whole or in part to offset its temperature discharge, so long as the trade results in at least a net thermal loading decrease in anthropogenic warming of the water body, and does not adversely affect a threatened or endangered species. Sources may also achieve compliance, in whole or in part, by flow augmentation, hyporheic exchange flows, outfall relocation, or other measures that reduce the temperature increase caused by the discharge.

(g) Release of Stored Water. Stored cold water may be released from reservoirs to cool downstream waters in order to achieve compliance with the applicable numeric criteria. However, there can be no significant adverse impact to downstream designated beneficial uses as a result of the releases of this cold water, and the release may not contribute to violations of other water quality criteria. Where the Department determines that the release of cold water is resulting in a significant adverse impact, the Department may require the elimination or mitigation of the adverse impact.

(13) Site-Specific Criteria. The Department may establish, by separate rulemaking, alternative site-specific criteria for all or a portion of a water body that fully protects the designated use.

(a) These site-specific criteria may be set on a seasonal basis as appropriate.

(b) The Department may use, but is not limited by the following considerations when calculating site-specific criteria:

(A) Stream flow;

(B) Riparian vegetation potential;

(C) Channel morphology modifications;

(D) Cold water tributaries and groundwater;

(E) Natural physical features and geology influencing stream temperatures; and

(F) Other relevant technical data.

(c) DEQ may consider the thermal benefit of increased flow when calculating the site-specific criteria.

(d) Once established and approved by EPA, the site-specific criteria will be the applicable criteria for the water bodies affected.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 468.020, 468B.030, 468B.035 & 468B.048
Stats. Implemented: ORS 468B.030, 468B.035 & 468B.048
Hist.: DEQ 17-2003, f. & cert. ef. 12-9-03; DEQ 1-2007, f. & cert. ef. 3-14-07; DEQ 2-2007, f. & cert. ef. 3-15-07; DEQ 10-2011, f. & cert. ef. 7-13-11; DEQ 5-2013, f. & cert. ef. 6-21-13

340-041-0061
Other Implementation of Water Quality Criteria

(1) A waste treatment and disposal facility may not be constructed or operated and wastes may not be discharged to public waters without a permit from the department in accordance with ORS 468B.050.

(2) Plans for all sewage and industrial waste treatment, control, and disposal facilities must be submitted to the department for review and approval prior to construction as required by ORS 468B.055.

(3) Minimum design criteria for waste treatment and control facilities prescribed under this plan and other waste treatment and controls deemed necessary to ensure compliance with the water quality standards contained in this plan must be provided in accordance with specific permit conditions for those sources or activities for which permits are required and the following implementation program.

(a) For new or expanded waste loads or activities, fully approved treatment or control facilities, or both, must be provided prior to discharge of any wastes from the new or expanded facilities or conduct of the new or expanded activity.

(b) For existing waste loads or activities, additional treatment or control facilities necessary to correct specific unacceptable water quality conditions must be provided in accordance with a specific program and timetable incorporated into the waste discharge permit for the individual discharger or activity. In developing treatment requirements and implementation schedules for existing installations or activities, consideration will be given to the impact upon the overall environmental quality, including air, water, land use, and aesthetics.

(c) Wherever minimum design criteria for waste treatment and control facilities set forth in this plan are more stringent than applicable federal standards and treatment levels currently being provided, upgrading to the more stringent requirements will be deferred until it is necessary to expand or otherwise modify or replace the existing treatment facilities. Such deferral will be acknowledged in the permit for the source.

(d) Where planning, design, or construction of new or modified waste treatment and controls to meet prior applicable state or federal requirements is underway at the time this plan is adopted, such plans, design, or construction may be completed under the requirements in effect when the project was initiated. Upgrading to meet more stringent future requirements will be timed in accordance with section (3) of this rule.

(4) Confined animal feeding operations (CAFOs) are regulated under OAR 340-051-0005 through 340-051-0080 to minimize potential adverse effect on water quality (see also OAR 603-074-0005 through 603-074-0070).

(5) Programs for control of pollution from nonpoint sources when developed by the department or by other agencies pursuant to section 208 of the federal Clean Water Act and approved by the department will be incorporated into this plan by amendment via the same process used to adopt the plan unless other procedures are established by law.

(6) Where minimum requirements of federal law or enforceable regulations are more stringent than specific provisions of this plan, the federal requirements will prevail.

(7) Within the framework of statewide priorities and available resources, the department will monitor water quality within the basin for the purposes of evaluating conformance with the plan and developing information for additions or updates.

(8) The commission recognizes that the potential exists for conflicts between water quality management plans and the land use plans and resource management plans that local governments and other agencies are required to develop. If conflicts develop, the department will meet with the local governments or responsible agencies to resolve the conflicts. Revisions will be presented for adoption via the same process used to adopt the plan unless other specific procedures are established by law.

(9) The department will calculate and include effluent limits specified in pounds per day, which will be the mass load limits for biochemical oxygen demand or carbonaceous biochemical oxygen demand and total suspended solids in National Pollutant Discharge Elimination System permits issued to all sewage treatment facilities. These limits must be calculated as follows.

(a) Except as noted in paragraph (H) of this subsection, the following requirements apply to existing facilities and to facilities receiving departmental approval for engineering plans and specifications for new treatment

facilities or treatment facilities expanding the average dry weather treatment capacity before June 30, 1992:

(A) During periods of low stream flows (approximately May 1 through October 31), the monthly average mass load expressed as pounds per day may not exceed the applicable monthly concentration effluent limit times the design average dry weather flow expressed in million gallons per day times 8.34. The weekly average mass load expressed as pounds per day may not exceed the monthly average mass load times 1.5. The daily mass load expressed in pounds per day may not exceed the monthly average mass load times 2.0.

(B) During the period of high stream flows (approximately November 1 through April 30), the monthly average mass load expressed as pounds per day may not exceed the monthly concentration effluent limit times the design average wet weather flow expressed in million gallons per day times 8.34. The weekly average mass load expressed as pounds per day may not exceed the monthly average mass load times 1.5. The daily mass load expressed in pounds per day may not exceed the monthly average mass load times 2.0.

(C) On any day that the daily flow to a sewage treatment facility exceeds the lesser hydraulic capacity of the secondary treatment portion of the facility or twice the design average dry weather flow, the daily mass load limit does not apply. The permittee must operate the treatment facility at highest and best practicable treatment and control.

(D) The design average wet weather flow used in calculating mass loads must be approved by the department in accordance with prudent engineering practice and must be based on a facility plan approved by the department, engineering plans and specifications approved by the department, or an engineering evaluation. The permittee must submit documentation describing and supporting the design average wet weather flow with the permit application, application for permit renewal, or modification request or upon request by the department. The design average wet weather flow is defined as the average flow between November 1 and April 30 when the sewage treatment facility is projected to be at design capacity for that portion of the year.

(E) Mass loads assigned as described in paragraphs (B) and (C) of this subsection will not be subject to OAR 340-041-0004(9);

(F) Mass loads as described in this rule will be included in permits upon renewal or upon a request for permit modification.

(G) Within 180 days after permit renewal or modification, a permittee receiving higher mass loads under this rule and having a separate sanitary sewer system must submit to the department for review and approval a proposed program and time schedule for identifying and reducing inflow. The program must include the following:

(i) Identification of all overflow points and verification that sewer system overflows are not occurring up to a 24-hour, five-year storm event or equivalent;

(ii) Monitoring of all pump station overflow points;

(iii) A program for identifying and removing all inflow sources into the permit holder's sewer system over which the permit holder has legal control; and

(iv) For those permit holders not having the necessary legal authority for all portions of the sewer system discharging into the permit holder's sewer system or treatment facility, a program and schedule for gaining legal authority to require inflow reduction and a program and schedule for removing inflow sources.

(H) Within one year after the department's approval of the program, the permit holder must begin implementation of the program.

(I) Paragraphs (A) through (G) of this subsection do not apply to the cities of Athena, Elgin, Adair Village, Halsey, Harrisburg, Independence, Carlton, and Sweet Home. Mass load limits have been individually assigned to these facilities.

(b) For new sewage treatment facilities or treatment facilities expanding the average dry weather treatment capacity and receiving engineering plans and specifications approval from the department after June 30, 1992, the mass load limits must be calculated by the department based on the proposed treatment facility capabilities and the highest and best practicable treatment to minimize the discharge of pollutants.

(c) Mass load limits as defined in this rule may be replaced by more stringent limits if required by waste load allocations established in accordance with a TMDL for treatment facilities discharging to water quality limited streams or if required to prevent or eliminate violations of water quality standards.

(d) If the design average wet weather flow or the hydraulic secondary treatment capacity is not known or has not been approved by the department at the time of permit issuance, the permit must include as interim mass load limits the mass load limits in the previous permit issued to the permit holder for the treatment facility. The permit must also include a requirement that the permit holder submit to the department the design average wet weather flow and hydraulic secondary treatment capacity within 12 months after permit issuance. Upon review and approval of the design flow information, the department will modify the permit and include mass load limits as described in subsection (a) of this section.

(e) Each permit holder with existing sewage treatment facilities otherwise subject to subsection (a) of this section may choose mass load limits calculated as follows:

(A) The monthly average mass load expressed as pounds per day may not exceed the applicable monthly concentration effluent limit times the design average dry weather flow expressed in million gallons per day times 8.34 pounds per gallon.

(B) The weekly average mass load expressed as pounds per day may not exceed the monthly average mass load times 1.5.

(C) The daily mass load expressed in pounds per day may not exceed the monthly average mass load times 2.0. If existing mass load limits are retained by the permit holder, the terms and requirements of subsection (a) of this section do not apply.

(f) The commission may grant exceptions to subsection (a) of this section. In allowing increased discharged loads, the commission must make the findings specified in OAR 340-041-0004(9)(a) for waste loads and the following findings:

(A) Mass loads calculated in subsection (a) of this section cannot be achieved with the existing treatment facilities operated at maximum efficiency at projected design flows; and

(B) There are no practicable alternatives to achieving the mass loads as calculated in subsection (a) of this section.

(12) Testing methods. The analytical testing methods for determining compliance with the water quality standards in this rule must comply with 40 CFR Part 136 or, if Part 136 does not prescribe a method, with the most recent edition of Standard Methods for the Examination of Water and Waste Water published jointly by the American Public Health Association, American Water Works Association, and Water Pollution Control Federation; if the department has published an applicable superseding method, testing must comply with the superseding method. Testing in accordance with an alternative method must comply with this rule if the department has published the method or has approved the method in writing.

(13) Reservoirs or managed lakes are deemed in compliance with water quality criteria for temperature, pH, or dissolved oxygen (DO) if all of the following circumstances exist.

(a) The water body has thermally stratified naturally or due to the presence of an impoundment.

(b) The water body has three observable layers, defined as the epilimnion, metalimnion, and hypolimnion.

(c) A layer exists in the reservoir or managed lake in which temperature, pH, and DO criteria are all met, and the layer is sufficient to support beneficial uses.

(d) All practicable measures have been taken by the entities responsible for management of the reservoir or managed lake to maximize the layers meeting the temperature, pH, and DO criteria.

(e) One of the following conditions is met:

(A) The streams or river segments immediately downstream of the water body meet applicable criteria for temperature, pH, and DO.

(B) All practicable measures have been taken to maximize downstream water quality potential and fish passage.

(C) If the applicable criteria are not met in the stream or river segment immediately upstream of the water body, then no further measurable downstream degradation of water quality has taken place due to stratification of the reservoir or managed lake.

(14) Compliance schedules. In a permit issued under OAR 340, division 045 or in a water quality certification under OAR 340, division 48, the department may include compliance schedules for the implementation of effluent limits derived from water quality criteria in this division. A compliance schedule in an NPDES permit is allowed only for water quality based effluent limits that are newly applicable to the permit and must comply with provisions in 40 CFR §122.47 (including the requirement that water quality criteria must be achieved as soon as possible).

Stat. Auth.: ORS 468.020, 468B.030, 468B.035 & 468B.048

Stats. Implemented: ORS 468B.030, 468B.035 & 468B.048

Hist.: DEQ 17-2003, f. & cert. ef. 12-9-03; DEQ 3-2004, f. & cert. ef. 5-28-04; DEQ 10-2011, f. & cert. ef. 7-13-11; DEQ 5-2013, f. & cert. ef. 6-21-13

Department of Fish and Wildlife
Chapter 635

Rule Caption: Amend Rule for Commercial Coastal Pelagic Species Management In the Pacific Ocean
Adm. Order No.: DFW 58-2013
Filed with Sec. of State: 6-19-2013
Certified to be Effective: 6-19-13
Notice Publication Date: 4-1-2013
Rules Amended: 635-004-0375
Subject: Oregon's commercial coastal pelagic species fisheries in the Pacific ocean off Oregon are jointly managed by the State and the federal government through the Pacific Fisheries Management Council process. Rule modifications bring the State of Oregon concurrent with federally adopted regulations. Housekeeping and technical corrections to the regulations are made to ensure rule consistency.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-004-0375
Scope, Inclusion, and Modification of Rules

(1) The commercial coastal pelagic species fishery in the Pacific Ocean off Oregon is jointly managed by the state of Oregon and the federal government through the Pacific Fishery Management Council process. The Code of Federal Regulations provides federal requirements for this fishery, including but not limited to the time, place, and manner of taking coastal pelagic species. However, additional regulations may be promulgated subsequently by publication in the Federal Register, and these supersede, to the extent of any inconsistency, the Code of Federal Regulations. Therefore, the following publications are incorporated into Oregon Administrative Rule by reference:

(a) Code of Federal Regulations, Part 660, Subpart I, (October 1, 2012 ed.); and

(b) Federal Register Vol. 78, No. 116, dated June 17, 2013 (78 FR 36117).

(2) Persons must consult the federal regulations in addition to Division 004 to determine all applicable coastal pelagic species fishing requirements. Where federal regulations refer to the fishery management area, that area is extended from shore to three nautical miles from shore coterminous with the Exclusive Economic Zone.

(3) The Commission may adopt additional or modified regulations that are more conservative than federal regulations, in which case Oregon Administrative Rule takes precedence. See OAR 635-004-0205 through 635-004-0235 and 635-004-0380 through 635-004-0545 for additions or modifications to federal coastal pelagic species regulations.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.138, 496.162, 506.036, 506.109, 506.119 & 506.129
Stats. Implemented: ORS 496.162, 506.109 & 506.129
Hist.: DFW 75-2012, f. 6-28-12, cert. ef. 7-1-12; DFW 110-2012(Temp), f. 8-21-12, cert. ef. 8-23-12 thru 9-14-12; Administrative correction 9-20-12; DFW 58-2013, f. & cert. ef. 6-19-13

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Rule Caption: Recreational White Sturgeon Fisheries in Columbia River Close Earlier Than Scheduled
Adm. Order No.: DFW 59-2013(Temp)
Filed with Sec. of State: 6-19-2013
Certified to be Effective: 6-21-13 thru 10-31-13
Notice Publication Date:
Rules Amended: 635-023-0095
Rules Suspended: 635-023-0095(T)
Subject: This amended rule closes previously set recreational white sturgeon fisheries earlier than scheduled due to higher than expected catch rates resulting in an early attainment of the pre-season harvest guideline. The areas being closed are: 1) the river mainstem from Wauna powerlines downstream to the mouth at Buoy 10 at 12:01 a.m. Friday, June 21, 2013; and 2) the Bonneville Pool at 12:01 a.m. Saturday, June 22, 2013. Rule modifications were made consistent with Joint State Action taken June 18, 2013 by Columbia River Compact agencies of the states of Oregon and Washington.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-023-0095
Sturgeon Season

(1) The **2013 Oregon Sport Fishing Regulations** provide requirements for the Columbia River Zone and the Snake River Zone. However, additional regulations may be adopted in this rule division from time to time, and, to the extent of any inconsistency, they supersede the **2013 Oregon Sport Fishing Regulations**.

(2) In 2013, the mainstem Columbia River from the Wauna powerlines (River Mile 40) upstream to Bonneville Dam, excluding the lower Willamette River upstream to Willamette Falls, Multnomah Channel, and the Gilbert River, is open to the retention of white sturgeon with a fork length of 38–54 inches, three days per week, Thursdays through Saturdays, during the following periods:

(a) January 1 through June 15; and

(b) October 19 through December 31.

(3) In 2013, the mainstem Columbia River from Wauna powerlines (River Mile 40) downstream to the mouth at Buoy 10, including Youngs Bay is open to the retention of white sturgeon seven days per week during the following periods:

(a) January 1 through April 30;

(b) May 11 through June 20.

(4) During the fishing period as identified in subsection (3)(a) of this rule, only white sturgeon with a fork length of 38–54 inches may be retained.

(5) During the fishing periods as identified in subsection (3)(b) of this rule, only white sturgeon with a fork length of 41–54 inches may be retained.

(6) Effective April 1, 2013, the annual bag and possession limit for white sturgeon is two (2) fish.

(7) Angling for sturgeon is prohibited from:

(a) Bonneville Dam downstream 9 miles to a line crossing the Columbia River from Navigation Marker 82 on the Oregon shore westerly to a boundary marker on the Washington shore upstream of Fir Point from May 1 through August 31;

(b) Highway 395 Bridge upstream to McNary Dam; and

(c) From the west end of the grain silo at Rufus upstream to John Day Dam during May 1 through July 31.

(8) Angling is prohibited for all species from the upper and lower ends of Sand Island and corresponding markers on the Oregon shoreline (slough at Rooster Rock State Park) from January 1 through April 30.

(9) The mainstem Columbia River from McNary Dam upstream to the Oregon-Washington border at river mile 309.5 is open to retention of white sturgeon with a fork length of 43–54 inches, seven days per week from February 1 through July 31.

(10) Retention of green sturgeon is prohibited all year in all areas.

(11) Catch-and-release angling is allowed year-round except as described above in sections (7)(a) through (7)(c) and (8) above.

(12) Effective January 1, 2014, the mainstem Columbia River from the mouth at Buoy 10 upstream to Bonneville Dam, including Oregon tributaries upstream to the mainline railroad bridges, is closed to the retention of white sturgeon.

(13) Effective: February 11 through June 13; June 16 through June 20; and June 22 through December 31, 2013, the retention of white sturgeon is prohibited in the mainstem Columbia River from Bonneville Dam upstream to The Dalles Dam (Bonneville Pool) including adjacent tributaries. Retention of white sturgeon between 38–54 inches in fork length is allowed in the area described in this section on June 14, 15, and 21, 2013 (3 days).

Stat. Auth.: ORS 183.325, 506.109 & 506.119
Stats. Implemented: ORS 506.129 & 507.030
Hist.: DFW 129-2004(Temp), f. 12-23-04, cert. ef 1-1-05 thru 2-28-05; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 22-2005(Temp), f. 4-1-05, cert. ef. 4-30-05 thru 7-31-05; DFW 50-2005(Temp), f. 6-3-05, cert. ef. 6-11-05 thru 11-30-05; DFW 60-2005(Temp), f. 6-21-05, cert. ef. 6-24-05 thru 12-21-05; DFW 65-2005(Temp), f. 6-30-05, cert. ef. 7-10-05 thru 12-31-05; DFW 76-2005(Temp), f. 7-14-05, cert. ef. 7-18-05 thru 12-31-05; DFW 136-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 145-2005(Temp), f. 12-21-05, cert. ef. 1-1-06 thru 3-31-06; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 19-2006(Temp), f. 4-6-06, cert. ef. 4-8-06 thru 7-31-06; DFW 54-2006(Temp), f. 6-29-06, cert. ef. 7-1-06 thru 12-27-06; DFW 62-2006(Temp), f. 7-13-06, cert. ef. 7-24-06 thru 12-31-06; DFW 79-2006, f. 8-11-06, cert. ef. 1-1-07; DFW 131-2006(Temp), f. 12-20-06, cert. ef. 1-1-07 thru 6-29-07; DFW 7-2007(Temp), f. 1-31-07, cert. ef. 2-1-07 thru 7-30-07; DFW 9-2007, f. & cert. ef. 2-14-07; DFW 20-2007(Temp), f. 3-26-07, cert. ef. 3-28-07 thru 7-30-07; DFW 38-2007(Temp), f. & cert. ef. 5-31-07 thru 11-26-07; DFW 59-2007(Temp), f. 7-18-07, cert .ef. 7-29-07 thru 12-31-07; DFW 75-2007(Temp), f. 8-17-07, cert. ef. 8-18-07 thru 12-31-07; DFW 102-2007(Temp), f. 9-28-07, cert. ef. 10-1-07 thru 12-31-07; DFW 135-2007(Temp), f. 12-28-07, cert. ef. 1-1-08 thru 6-28-08; DFW 136-2007, f. 12-31-07, cert. ef. 1-1-08; DFW 8-2008, f. & cert. ef. 2-11-08; DFW 23-2008(Temp), f. 3-12-08, cert. ef. 3-15-08 thru 9-10-08; DFW 28-2008(Temp), f. 3-24-08, cert. ef. 3-26-08 thru 9-10-08; DFW 72-2008(Temp), f. 6-30-08, cert. ef. 7-10-08 thru 12-31-08; DFW 78-2008(Temp), f. 7-9-08, cert. ef. 7-12-08 thru 12-31-08; DFW 86-2008(Temp), f. & cert. ef. 7-25-08 thru 12-31-08; DFW 148-2008(Temp), f. 12-19-08, cert. ef. 1-1-09 thru 6-29-09; DFW 156-2008, f. 12-31-08, cert. ef. 1-1-09; DFW 18-2009, f. & cert. ef. 2-26-09; DFW 33-2009(Temp), f. 4-2-09, cert ef. 4-13-09 thru 10-9-09; DFW 63-2009(Temp), f. 6-3-09, cert. ef. 6-6-09 thru 10-9-09; DFW 83-2009(Temp), f. 7-8-09, cert. ef. 7-9-09 thru 12-31-09; DFW 86-2009(Temp), f. 7-22-09, cert. ef. 7-24-09 thru 12-31-09; DFW 144-2009, f. 12-8-09, cert. ef. 1-1-10; DFW 13-2010(Temp), f. 2-16-10, cert. ef. 2-21-10 thru 7-31-10; DFW 19-2010(Temp), f. 2-26-10, cert. ef. 3-1-10 thru 8-27-10; DFW 34-2010, f. 3-16-10, cert. ef. 4-1-10; DFW 49-2010(Temp), f. 4-27-10, cert. ef. 4-29-10 thru

7-31-10; DFW 50-2010(Temp), f. 4-29-10, cert. ef. 5-6-10 thru 11-1-10; DFW 88-2010(Temp), f. 6-25-10, cert. ef. 6-26-10 thru 7-31-10; DFW 91-2010(Temp), f. 6-29-10, cert. ef. 8-1-10 thru 12-31-10; DFW 99-2010(Temp), f. 7-13-10, cert. ef. 7-15-10 thru 12-31-10; DFW 165-2010(Temp), f. 12-28-10, cert. ef. 1-1-11 thru 6-29-11; DFW 171-2010, f. 12-30-10, cert. ef. 1-1-11; DFW 11-2011(Temp), f. 2-10-11, cert. ef. 2-11-1 thru 7-31-11; DFW 23-2011, f. & cert. ef. 3-21-11; DFW 26-2011(Temp), f. 4-5-11, cert. ef. 4-10-11 thru 9-30-11; DFW 74-2011(Temp), f. 6-24-11, cert. ef. 6-27-11 thru 7-31-11; DFW 87-2011(Temp), f. 7-8-11, cert. ef. 7-9-11 thru 7-31-11; DFW 96-2011(Temp), f. 7-20-11, cert. ef. 7-30-11 thru 12-31-11; DFW 129-2011(Temp), f. 9-15-11, cert. ef. 9-30-11 thru 12-31-11; DFW 163-2011, f. 12-27-11, cert. ef. 1-1-12; DFW 1-2012(Temp), f. & cert. ef. 1-5-12 thru 7-2-12; DFW 10-2012, f. & cert. ef. 2-7-12; DFW 16-2012(Temp), f. 2-14-12, cert. ef. 2-18-12 thru 7-31-12; DFW 44-2012(Temp), f. 5-1-12, cert. ef. 5-20-12 thru 7-31-12; DFW 73-2012(Temp), f. 6-29-12, cert. ef. 7-1-12 thru 8-31-12; DFW 97-2012(Temp), f. 7-30-12, cert. ef. 8-1-12 thru 12-31-12; DFW 129-2012(Temp), f. 10-3-12, cert. ef. 10-20-12 thru 12-31-12; DFW 140-2012(Temp), f. 10-31-12, cert. ef. 11-4-12 thru 12-31-12; DFW 152-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 154-2012(Temp), f. 12-28-12, cert. ef. 1-1-13 thru 2-28-13; DFW 12-2013(Temp), f. 2-12-13, cert. ef. 2-28-13 thru 7-31-13; DFW 23-2013(Temp), f. 3-20-13, cert. ef. 4-1-13 thru 9-27-13; DFW 47-2013(Temp), f. 5-30-13, cert. ef. 6-14-13 thru 9-30-13; DFW 59-2013(Temp), f. 6-19-13, cert. ef. 6-21-13 thru 10-31-13

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Rule Caption: Three Rivers Angling Regulations Modified Effective June 30, 2013
Adm. Order No.: DFW 60-2013(Temp)
Filed with Sec. of State: 6-24-2013
Certified to be Effective: 6-30-13 thru 9-30-13
Notice Publication Date:
Rules Amended: 635-014-0090
Subject: The rule modifications delay the spring Chinook fishery closure at Three Rivers from July 1 until July 16, 2013 in order to allow anglers greater opportunity to harvest hatchery spring Chinook by extending the season.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-014-0090
Inclusions and Modifications

(1) The **2013 Oregon Sport Fishing Regulations** provide requirements for the Northwest Zone. However, additional regulations may be adopted in this rule division from time to time and to the extent of any inconsistency, they supersede the **2013 Oregon Sport Fishing Regulations** pamphlet.

(2) Notwithstanding all other requirements provided in the **2013 Oregon Sport Fishing Regulations** pamphlet, the following additional rules apply to adult salmon angling in waters of the Northwest Zone:

(a) All waters of the Necanicum River Basin, Nehalem River Basin (including North Fork), Tillamook Bay Basin, (including the Miami, Kilchis, Wilson, Trask, and Tillamook rivers), and the Nestucca River Basin (including the Little Nestucca and Three Rivers) Salmon River, Siletz River (including Drift Creek), and Yaquina River that are open for Chinook salmon are limited to no more than 2 adult non fin-clipped Chinook salmon per day, and 10 adult non fin-clipped Chinook salmon in the seasonal aggregate when combined with all other waters in the Northwest Zone with a 10 adult non fin-clipped Chinook salmon seasonal aggregate limit. Seasonal aggregate applies to all adult non fin-clipped Chinook salmon retained between August 1 and December 31 except in the Nehalem Basin where the seasonal aggregate applies to all adult non fin-clipped Chinook salmon retained between July 1 and December 31.

(A) Three Rivers (Nestucca Basin, Tillamook/Yamhill Co.) mainstem: Open for adipose *steelhead* all year. Open for adipose fin-clipped *spring Chinook salmon* April 1–July 15;

(B) Closed from mouth upstream to hatchery weir deadline July 16-Sept. 30;

(C) From May 1-July 15, use of leaders longer than 36 inches is prohibited. Hooks are limited to no more than one single point, size 3/8-inch gap width (approximately size #2) or smaller hook; and

(D) All other requirements provided at the bottom of page 32 of the **2013 Oregon Sport Fishing Regulations** pamphlet apply.

(b) Within the Nehalem River Basin (including the North Fork) the following additional rules apply:

(A) Mainstem closed to all salmon angling upstream of Foss Road (CC) Bridge (RM 15.5) July 1 through December 31.

(B) Nehalem Bay tidewater from the jetty tips upstream to Miami-Foley Bridge on South Fork and North Fork Road Bridge on the North Fork is open for non adipose fin-clipped coho salmon from September 15 through the earlier of November 30 or attainment of an adult coho salmon quota of 700 non adipose fin-clipped coho salmon.

(C) The daily catch limit may include one adult non adipose fin-clipped coho salmon per day and one non adipose fin-clipped jack coho salmon per day, and no more than one total adult non adipose fin-clipped coho salmon in the seasonal aggregate from all waters in the Northwest Zone with a one adult non adipose fin-clipped coho salmon seasonal aggregate limit (Nestucca River and Tillamook Bay Basin).

(c) Within the Tillamook Bay Basin the following additional rules apply:

(A) Tillamook Bay tidewater from the jetty tips upstream to Highway 101 Bridge on Miami, Kilchis, Wilson, and Trask rivers and Burton Bridge on Tillamook River is open on Fridays and Saturdays only for non adipose fin-clipped coho salmon from September 20 through the earlier of November 30 or attainment of an adult coho salmon quota of 500 non adipose fin-clipped coho salmon.

(B) The daily catch limit may include one adult non adipose fin-clipped coho salmon per day and one non adipose fin-clipped jack coho salmon per day, and no more than one total adult non adipose fin-clipped coho salmon in the seasonal aggregate from all waters in the Northwest Zone with a one adult non adipose fin-clipped coho salmon seasonal aggregate limit (Nestucca River and Nehalem River Basin).

(d) Within the Nestucca River Basin (including the Little Nestucca River and Three Rivers) the following rules apply:

(A) Mainstem Nestucca River upstream of First Bridge (RM 15.8) near Beaver closed to all salmon angling August 1 through December 31.

(B) Nestucca Bay tidewater (excluding Little Nestucca tidewater) from the bay mouth upstream to the Cloverdale Bridge (RM 7.1) is open on Sundays and Mondays only for non adipose fin-clipped coho salmon from September 15 through the earlier of November 25 or attainment of an adult coho salmon quota of 200 non adipose fin-clipped coho salmon.

(C) The daily catch limit may include one adult non adipose fin-clipped coho salmon per day and one non adipose fin-clipped jack coho salmon per day, and no more than one total adult non adipose fin-clipped coho salmon in the seasonal aggregate from all waters in the Northwest Zone with a one adult non adipose fin-clipped coho salmon seasonal aggregate limit (Nehalem River and Tillamook Bay Basin).

(e) Within the Siletz River Basin the following additional rules apply:

(A) Mainstem and tributaries above an ODFW marker sign approximately 1,200 feet upstream of Ojalla Bridge (RM 31) closed to Chinook August 1-December 31; Drift Creek (Siletz River Basin) upstream of the confluence with Quarry Creek at RM 8 is closed for Chinook salmon from August 1 through December 31;

(B) Siletz River and Bay upstream to an ODFW marker sign approximately 1,200 feet upstream of Ojalla Bridge (RM 31) is open for non adipose fin-clipped coho salmon from September 15 through November 30; and

(C) The daily catch limit may include one adult non adipose fin-clipped coho salmon per day and one non adipose fin-clipped jack coho salmon per day, and no more than 2 total adult non adipose fin-clipped coho salmon in the seasonal aggregate from all waters in the Northwest Zone and Southwest Zone with a 2 adult non adipose fin-clipped coho salmon seasonal aggregate limit (Yaquina River, Alsea River, Siuslaw River, Umpqua River, Beaver Creek (Ona Beach), Floras Creek/New River, Coos River, and Coquille River).

(f) Within the Yaquina River Basin the following additional rules apply:

(A) All waters of the Yaquina River upstream of the confluence of the Yaquina River and Big Elk Creek at RM 18.3 and all waters of Big Elk Creek (Yaquina River Basin) are closed for Chinook salmon from August 1 through December 31;

(B) The Yaquina River and Bay upstream to the confluence of the Yaquina River and Big Elk Creek are open for non adipose fin-clipped coho salmon from September 15 through November 30; and

(C) The daily catch limit may include one adult non adipose fin-clipped coho salmon per day and one non adipose fin-clipped jack coho salmon per day, and no more than 2 total adult non adipose fin-clipped coho salmon in the seasonal aggregate from all waters in the Northwest Zone and Southwest Zone with a 2 adult non adipose fin-clipped coho salmon seasonal aggregate limit (Siletz River, Alsea River, Siuslaw River, Umpqua River, Beaver Creek (Ona Beach), Floras Creek/New River, Coos River, and Coquille River).

(g) Within the Alsea River Basin the following additional rules apply:

(A) All waters of Drift Creek (Alsea River Basin) within the Drift Creek Wilderness Area and upstream are closed for Chinook salmon from August 1 through December 31;

(B) All waters of Five Rivers are closed for Chinook salmon from August 1 through December 31.

(C) The Alsea River and Bay upstream to the USFS River Edge Boat Landing are open for non adipose fin-clipped coho salmon from September 15 through November 30; and

(D) The daily catch limit may include one adult non adipose fin-clipped coho salmon per day and one non adipose fin-clipped jack coho salmon per day, and no more than 2 total adult non adipose fin-clipped coho salmon in the seasonal aggregate from all waters in the Northwest Zone and Southwest Zone with a 2 adult non adipose fin-clipped coho salmon seasonal aggregate limit (Siletz River, Yaquina River, Siuslaw River, Umpqua River, Beaver Creek (Ona Beach), Floras Creek/New River, Coos River, and Coquille River).

(h) Within the Siuslaw River Basin the following additional rules apply:

(A) All waters of the Siuslaw River upstream of the confluence with Lake Creek at RM 30.0 are closed for Chinook salmon from August 1 through December 31;

(B) All waters of Lake Creek are closed for Chinook salmon August 1 through October 15 and all waters of Lake Creek upstream from the mouth of Indian Creek (RM 2.5) and downstream of Fish Creek (RM 17) are closed for angling for Chinook salmon the entire year and closed to all angling from September 1 through November 30;

(C) The Siuslaw River and Bay upstream to the confluence of the Siuslaw River with Lake Creek is open for non adipose fin-clipped coho salmon from September 15 through November 30; and

(D) Lake Creek upstream to the mouth of Indian Creek (RM 2.5) is open to non adipose fin-clipped coho salmon from October 16 through November 30;

(E) The daily catch limit may include one adult non adipose fin-clipped coho salmon per day and one non adipose fin-clipped jack coho salmon per day, and no more than 2 total adult non adipose fin-clipped coho salmon in the seasonal aggregate from all waters in the Northwest Zone and Southwest Zone with a 2 adult non adipose fin-clipped coho salmon seasonal aggregate limit (Yaquina River, Alsea River, Siletz River, Umpqua River, Beaver Creek (Ona Beach), Floras Creek/New River, Coos River, and Coquille River).

(i) Beaver Creek (at Ona Beach between Newport and Waldport) from footbridge west of Highway 101 upstream to the confluence of South Fork Beaver Creek (Ona Beach) open on Saturdays and Sundays ONLY for non adipose fin-clipped coho salmon from November 1-30 or until attainment of an adult coho quota of 150 fish. The daily catch limit may include one adult non adipose fin-clipped coho salmon per day and one non adipose fin-clipped jack coho salmon per day, and no more than 2 non adipose fin-clipped salmon in the seasonal aggregate from all waters in the Northwest Zone and Southwest Zone with a 2 adult non adipose fin-clipped coho season aggregate limit (Siletz River, Yaquina River, Alsea River, Siuslaw River, Umpqua River, Floras Creek/New River, Coos River, and Coquille River).

(3) Effective January 1, 2013, the use of barbless hooks is required when angling for salmon, steelhead, or trout in the following areas:

(a) Within the Youngs Bay Select Area (Clatsop County) from the Highway 101 Bridge upstream to markers at the confluence of the Youngs and Klaskanine rivers including the lower Lewis and Clark River upstream to the Alternate Highway 101 Bridge, and the lower Walluski River upstream to the Highway 202 Bridge.

(b) In Gnat Creek (Clatsop County) from the railroad bridge upstream to the Aldrich Point Road Bridge.

(4) Effective January 1, 2013, the annual bag limit for white sturgeon is one (1) fish. Effective April 1, 2013, the annual bag and possession limit for white sturgeon is two (2) fish. Catch-and-release angling for white sturgeon is allowed year-round. Effective January 1, 2014, all waters within the Northwest Zone are closed to the retention of white sturgeon and catch-and-release angling is allowed year-round.

Stat. Auth.: ORS 496.138, 496.146, 497.121 & 506.119

Stats. Implemented: ORS 496.004, 496.009, 496.162 & 506.129

Hist.: FWC 82-1993, f. 12-22-93, cert. ef. 1-1-94; FWC 21-1994(Temp), f. 4-22-94, cert. ef. 4-25-94; FWC 31-1994, f. 5-26-94, cert. ef. 6-20-94; FWC 65-1994(Temp), f. 9-15-94, cert. ef. 9-17-94; FWC 22-1995, f. 3-7-95, cert. ef. 3-10-95; FWC 28-1995(Temp), f. 3-31-95, cert. ef. 5-1-95; FWC 34-1995, f. & cert. ef. 5-1-95; FWC 39-1995, f. 5-10-95, cert. ef. 5-12-95; FWC 77-1995, f. 9-13-95, cert. ef. 1-1-96; FWC 19-1996, f. & cert. ef. 5-16-96; FWC 20-1996, f. & cert. ef. 4-29-96; FWC 29-1996, f. & cert. ef. 5-31-96; FWC 46-1996, f. & cert. ef. 8-23-96; FWC 55-1996(Temp), f. 9-25-96, cert. ef. 10-1-96; FWC 72-1996, f. 12-31-96, cert. ef. 1-1-97; FWC 73-1996(Temp), f. 12-31-96, cert. ef. 1-1-97; FWC 5-1997, f. & cert. ef. 2-4-97; FWC 30-1997, f. & cert. ef. 5-5-97; FWC 58-1997, f. 9-8-97, cert. ef. 10-1-97; FWC 75-1997, f. 12-31-97, cert. ef. 1-1-98; DFW 12-1998(Temp), f. & cert. ef. 2-24-98 thru 4-24-98; DFW 34-1998, f. & cert. ef. 5-4-98; DFW 69-1998, f. 8-28-98, cert. ef. 9-1-98; DFW 100-1998, f. 12-23-98, cert. ef. 1-1-99; DFW 36-1999, f. & cert. ef. 5-20-99; DFW 96-1999, f. 12-27-99, cert. ef. 1-1-00; DFW 24-2000, f. 4-28-00, cert. ef. 5-1-00; DFW 83-2000(Temp), f. 12-28-00, cert. ef. 1-1-01 thru 1-31-01; DFW 1-2001, f. 1-25-01, cert. ef. 2-1-01; DFW 28-2001, f. & cert. ef. 5-1-01; DFW 40-2001(Temp) f. & cert. ef. 5-24-01 thru 11-20-01; DFW 72-2001(Temp), f. 8-10-01, cert. ef. 8-16-01 thru 12-31-01; DFW 81-2001, f. & cert. ef. 8-29-01; DFW 85-2001(Temp), f. & cert. ef. 8-30-01 thru 12-31-01; DFW 90-2001(Temp), f. 9-14-01, cert. ef. 9-15-01 thru 12-31-01; DFW 123-2001, f. 12-31-01, cert. ef. 1-1-02; DFW 5-2002(Temp) f. 1-11-02 cert. ef. 1-12-02 thru 7-11-02; DFW 26-2002, f. & cert. ef. 3-21-02; DFW 37-2002, f. & cert. ef. 4-23-02; DFW 91-2002(Temp) f. 8-19-02, cert. ef 8-20-02 thru 11-1-02 (Suspended by DFW 101-2002(Temp), f. & cert. ef. 10-3-02 thru 11-1-02); DFW 118-2002(Temp), f, 10-22-02, cert. ef. 12-1-02 thru 3-31-03; DFW 120-2002(Temp), f. 10-24-02, cert. ef. 10-26-02 thru 3-31-03; DFW 130-2002, f. 11-21-02, cert. ef. 1-1-03; DFW 18-2003(Temp) f. 2-28-03, cert. ef. 3-1-03 thru 4-30-03; DFW 38-2003(Temp), f. 5-7-03, cert. ef. 5-10-03 thru 10-31-03; DFW 51-2003(Temp), f. & cert. ef. 6-13-03 thru 10-31-03; DFW 90-2003(Temp), f. 9-12-03 cert. ef. 9-13-03 thru 12-31-03; DFW 108-2003(Temp), f. 10-28-03, cert. ef. 12-1-03 thru 3-31-04; DFW 123-2003(Temp), f. 12-10-03, cert. ef. 12-11-03 thru 12-31-03; DFW 125-2003, f. 12-11-03, cert. ef. 1-1-04; DFW 126-2003(Temp), f. 12-11-03, cert. ef. 1-1-04 thru 3-31-04; DFW 60-2004(Temp), f. 6-29-04, cert. ef 7-1-04 thru 7-15-04; DFW 90-2004(Temp), f. 8-30-04, cert. ef. 10-1-04 thru 12-31-04; DFW 103-2004(Temp), f. & cert, ef, 10-4-04 thru 12-31-04; DFW 108-2004(Temp), f. & cert. ef. 10-18-04 thru 12-31-04; DFW 111-2004(Temp), f. 11-16-04, cert. ef. 11-20-04 thru 12-31-04; DFW 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 62-2005(Temp), f. 6-29-05, cert. ef. 7-1-05 thru 7-10-05; Administrative correction 7-20-05; DFW 105-2005(Temp), f. 9-12-05, cert. ef. 10-1-05 thru 12-15-05; DFW 127-2005(Temp), f. & cert. ef. 11-23-05 thru 12-31-05; DFW 136-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 53-2006(Temp), f. 6-29-06, cert. ef. 7-1-06 thru 7-9-06; Administrative correction 7-20-06; DFW 64-2006(Temp), f. 7-17-06, cert. ef. 8-1-06 thru 12-31-06; DFW 79-2006, f. 8-11-06, cert. ef. 1-1-07; DFW 104-2006(Temp), f. 9-19-06, cert. ef. 10-1-06 thru 12-31-06; DFW 24-2007, f. 4-16-07, cert. ef. 5-1-07; DFW 63-2007(Temp), f. 8-6-07, cert. ef. 8-11-07 thru 12-31-07; DFW 136-2007, f. 12-31-07, cert. ef. 1-1-08; DFW 25-2008(Temp), f. 3-13-08, cert. ef. 3-15-08 thru 9-10-08; DFW 67-2008(Temp), f. 6-20-08, cert. ef. 8-1-08 thru 12-31-08; DFW 156-2008, f. 12-31-08, cert. ef. 1-1-09; DFW 43-2009(Temp), f. 5-5-09, cert. ef. 5-22-09 thru 10-31-09; DFW 67-2009(Temp), f. 6-9-09, cert. ef. 6-15-09 thru 10-31-09; DFW 87-2009(Temp), f. 7-31-09, cert. ef. 8-1-09 thru 12-31-09; DFW 99-2009(Temp), f. 8-26-09, cert. ef. 9-1-09 thru 12-31-09; DFW 115-2009(Temp), f. & cert. ef. 9-22-09 thru 12-31-09; DFW 144-2009, f. 12-8-09, cert. ef. 1-1-10; DFW 44-2010(Temp), f. 4-20-10, cert. ef. 4-21-10 thru 9-30-10; DFW 73-2010(Temp), f. 5-27-10, cert. ef. 6-1-10 thru 9-30-10; DFW 76-2010, f. 6-8-10, cert. ef. 8-1-10; DFW 89-2010(Temp), f. 6-28-10, cert. ef. 7-1-10 thru 9-30-10; Administrative correction 10-26-10; DFW 171-2010, f. 12-30-10, cert. ef. 1-1-11; DFW 57-2011(Temp), f. 5-27-11, cert. ef. 6-1-11 thru 6-30-11; DFW 83-2011, f. 6-30-11, cert. ef. 7-1-11; DFW 139-2011(Temp), f. 10-3-11, cert. ef. 10-6-11 thru 12-31-11; DFW 141-2011(Temp), f. 10-6-11, cert. ef. 10-10-11 thru 12-31-11; DFW 143-2011(Temp), f. 10-10-11, cert. ef. 10-11-11 thru 12-31-11; DFW 148-2011(Temp), f. 10-20-11, cert. ef. 10-21-11 thru 12-31-11; DFW 163-2011, f. 12-27-11, cert. ef. 1-1-12; DFW 53-2012(Temp), f. 5-29-12, cert. ef. 6-1-12 thru 10-31-12; DFW 62-2012, f. 6-12-12, cert. ef. 7-1-12; DFW 63-2012(Temp), f. & cert. ef. 6-12-12 thru 10-31-12; DFW 71-2012(Temp), f. 6-27-12, cert. ef. 7-1-12 thru 11-30-12; DFW130-2012(Temp), f. 10-10-12, cert. ef. 10-13-12 thru 12-31-12; DFW 135-2012(Temp), f. 10-22-12, cert. ef. 10-24-12 thru 12-31-12; DFW 139-2012(Temp), f. 10-30-12, cert. ef. 10-31-12 thru 12-31-12; DFW 152-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 23-2013(Temp), f. 3-20-13, cert. ef. 4-1-13 thru 9-27-13; DFW 43-2013(Temp), f. 5-29-13, cert. ef. 6-1-13 thru 10-31-13; DFW 50-2013, f. 6-10-13, cert. ef. 7-1-13; DFW 60-2013(Temp), f. 6-24-13, cert. ef. 6-30-13 thru 9-30-13

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Rule Caption: Additional Harvest Opportunity During Recreational Fishing Season for Lofton Reservoir
Adm. Order No.: DFW 61-2013(Temp)
Filed with Sec. of State: 6-24-2013
Certified to be Effective: 7-1-13 thru 12-27-13
Notice Publication Date:
Rules Amended: 635-021-0090
Subject: This amended rule liberalizes daily catch or possession limits and gear types, and removes size limits for game fish in Lofton Reservoir from July 1 through October 13, 2013. The Reservoir is scheduled for treatment with rotenone on October 22, 2013. These modifications will aid in reducing fish stocks prior to eradication of all fish in the lake.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-021-0090
Inclusions and Modifications

(1) The **2013 Oregon Sport Fishing Regulations** provide requirements for the Southeast Zone. However, additional regulations may be adopted in this rule division from time to time and to the extent of any inconsistency, they supersede the **2013 Oregon Sport Fishing Regulations**.

(2) Lofton Reservoir (Lake County) is open to angling for all game fish species from July 1 through October 13, 2013 with the following restrictions:

(a) Allowed harvest methods are by hand, dip net, or angling;

(b) There are no daily catch and possession limits; and

(c) There are no minimum length requirements.

(3) Lofton Reservoir is closed to all angling and harvest methods from October 14, 2013 through March 31, 2014.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 183.325, 496.138 & 496.146

Stats. Implemented: ORS 496.162

Hist.: FWC 82-1993, f. 12-22-93, cert. ef. 1-1-94; FWC 76-1994(Temp), f. & cert. ef. 10-17-94; FWC 22-1995, f. 3-7-95, cert. ef. 3-10-95; FWC 77-1995, f. 9-13-95, cert. ef. 1-1-96; FWC 72-1996, f. 12-31-96, cert. ef. 1-1-97; FWC 75-1997, f. 12-31-97, cert. ef. 1-1-98; DFW 100-1998, f. 12-23-98, cert. ef. 1-1-99; DFW 96-1999, f. 12-27-99, cert. ef. 1-1-00; DFW 83-2000(Temp), f. 12-28-00, cert. ef. 1-1-01 thru 1-31-01; DFW 1-2001, f. 1-25-01,

cert. ef. 2-1-01; DFW 40-2001(Temp) f. & cert. ef. 5-24-01 thru 11-20-01; DFW 55-2001(Temp), f. & cert. ef. 6-29-01 thru 12-26-01; DFW 85-2001(Temp), f. & cert. ef. 8-30-01 thru 12-31-01; DFW 123-2001, f. 12-31-01, cert. ef. 1-1-02; DFW 26-2002, f. & cert. ef. 3-21-02; DFW 54-2002(Temp), f. 5-24-02, cert. ef. 6-15-02 thru 12-1-02; DFW 91-2002(Temp) f. 8-19-02,cert. ef 8-20-02 thru 11-1-0 2 (Suspended by DFW 101-2002(Temp), f. & cert. ef. 10-3-02 thru 11-1-02); DFW 93-2002(Temp), f. 8-22-02, cert. ef. 8-24-02 thru 12-31-02; DFW 130-2002, f. 11-21-02, cert. ef. 1-1-03; DFW 80-2003(Temp), f. & cert. ef. 8-22-03 thru 9-30-03; DFW 125-2003, f. 12-11-03, cert. ef. 1-1-04; DFW 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 101-2005(Temp), f. 8-31-05, cert. ef. 9-2-05 thru 9-30-05; Administrative correction 10-19-05; DFW 136-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 79-2006, f. 8-11-06, cert. ef. 1-1-07; DFW 36-2007(Temp), f. 5-25-07, cert. ef. 5-26-07 thru 9-30-07; DFW 54-2007(Temp), f. 7-6-07, cert. ef. 7-14-07 thru 9-30-07; DFW 62-2007(Temp), f. 7-31-07, cert. ef. 8-1-07 thru 9-30-07; Administrative correction 10-16-07; DFW 136-2007, f. 12-31-07, cert. ef. 1-1-08; DFW 51-2008(Temp), f. 5-16-08, cert. ef. 5-31-08 thru 9-1-08; DFW 74-2008(Temp), f. 7-3-08, cert. ef. 7-4-08 thru 9-1-08; DFW 77-2008(Temp), f. & cert. ef. 7-9-08 thru 9-1-08; Administrative correction 9-29-08; DFW 156-2008, f. 12-31-08, cert. ef. 1-1-09; DFW 53-2009(Temp), f. 5-18-09, cert. ef. 5-30-09 thru 9-1-09; DFW 62-2009(Temp), f. 6-2-09, cert. ef. 6-13-09 thru 9-1-09; DFW 79-2009(Temp), f. 6-30-09, cert. ef. 7-5-09 thru 9-1-09; Administrative correction 9-29-09; DFW 144-2009, f. 12-8-09, cert. ef. 1-1-10; DFW 52-2010(Temp), f. 4-30-10, cert. ef. 5-1-10 thru 9-30-10; DFW 60-2010(Temp), f. 5-13-10, cert. ef. 5-22-10 thru 9-30-10; DFW 67-2010(Temp), f. 5-18-10, cert. ef. 5-22-10 thru 9-30-10; DFW 78-2010(Temp), f. 6-10-10, cert. ef. 6-11-10 thru 9-1-10; Administrative correction 9-22-10; DFW 171-2010, f. 12-30-10, cert. ef. 1-1-11; DFW 50-2011(Temp), f. 5-16-11, cert. ef. 5-28-11 thru 9-1-11; Administrative correction 9-23-11; DFW 163-2011, f. 12-27-11, cert. ef. 1-1-12; DFW 60-2012(Temp), f. 6-11-12, cert. ef. 6-13-12 thru 9-1-12; DFW 114-2012(Temp), f. 8-30-12, cert. ef. 9-1-12 thru 2-27-13; DFW 117-2012(Temp), f. 9-5-12, cert. ef. 9-7-12 thru 2-27-13; DFW 122-2012(Temp), f. 9-21-12, cert. ef. 9-21-12 thru 12-31-12; DFW 149-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 61-2013(Temp), f. 6-24-13, cert. ef. 7-1-13 thru 12-27-13

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Rule Caption: Spring Chinook Fisheries in the Imnaha River
Adm. Order No.: DFW 62-2013(Temp)
Filed with Sec. of State: 6-26-2013
Certified to be Effective: 7-5-13 thru 12-31-13
Notice Publication Date:
Rules Amended: 635-019-0090
Rules Suspended: 635-019-0090(T)
Subject: This amended rule allows recreational anglers opportunity to harvest adipose fin-clipped adult and jack Chinook salmon, which are in excess of the Department's hatchery production needs, in the Imnaha River beginning Friday, July 5, 2013. Harvest of adipose-clipped adult salmon will only be allowed through July 7, 2013. Thereafter jack salmon may be harvested with a daily bag limit of five jacks.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-019-0090
Inclusions and Modifications

(1) The **2013 Oregon Sport Fishing Regulations** provide requirements for the Northeast Zone. However, additional regulations may be adopted in this rule division from time to time and to the extent of any inconsistency, they supersede the **2013 Oregon Sport Fishing Regulations**.

(2) The Umatilla River, from the Highway 730 bridge upstream to the Reservation boundary located upstream from the Highway 11 bridge at Pendleton is closed to spring Chinook angling effective 12:01 a.m. Thursday, May 16, 2013. All other sport fishing regulations as stated on page 74 of the 2013 Oregon Sport Fishing Regulations remain in effect.

(3) Special regulations for Wallowa Lake have been modified to allow for a daily bag limit of twenty (20) kokanee per day, no minimum length and no more than five (5) over 12 inches in length. All other General, Statewide and Northeast Zone Regulations, as provided in the 2013 Oregon Sport Fishing Regulations, remain in effect.

(4) Lookingglass Creek from the Moses Creek Lane Bridge (County Road 42) to the confluence of Jarboe Creek is open to angling for adipose fin-clipped jack Chinook salmon from June 1 through June 21, 2013.

(a) The daily bag limit is five (5) adipose fin-clipped jacks; two daily limits in possession. All adult Chinook must be released unharmed.

(b) During the duration of the spring Chinook angling season as described in section (4) above, the area closure listed for Lookingglass Creek in the 2013 Oregon Sport Fishing Regulations, Northeast Zone Special Regulations is modified to read: Lookingglass Creek closed between Jarboe Creek and 200 feet upstream of the hatchery water intake.

(c) Hook gap restrictions listed in the Northeast Zone Special Regulations for Lookingglass Creek are removed for the duration of the spring Chinook angling season described in section (4) above.

(d) All other General, Statewide and Northeast Zone Regulations, as provided in the 2013 Oregon Sport Fishing Regulations, remain in effect.

(5) The Imnaha River from the mouth to Summit Creek Bridge (River Mile 45) is open to angling for adipose fin-clipped adult Chinook salmon beginning July 5, 2013.

(a) From July 5 through July 7, the daily bag limit is two (2) adipose fin-clipped adult Chinook and five (5) adipose fin-clipped jacks; two daily jack salmon limits in possession. It is illegal to continue fishing for jack Chinook once the adult bag limit has been met.

(b) After July 7, the daily bag limit is five (5) adipose fin-clipped jacks; two daily jack salmon limits in possession; and adult Chinook salmon may not be retained.

(c) All other General, Statewide and Northeast Zone Regulations, as provided in the 2013 Oregon Sport Fishing Regulations, remain in effect.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: 496.162 & 506.129
Hist.: FWC 82-1993, f. 12-22-93, cert. ef. 1-1-94; FWC 57-1994(Temp), f. 8-30-94, cert. ef. 10-1-94; FWC 22-1995, f. 3-7-95, cert. ef. 3-10-95; FWC 70-1995, f. 8-29-95, cert. ef. 9-1-95; FWC 77-1995, f. 9-13-95, cert. ef. 1-1-96; FWC 27-1996(Temp), f. 5-24-96, cert. ef. 5-25-96; FWC 57-1996(Temp), f. 9-27-96, cert. ef. 10-1-96; FWC 72-1996, f. 12-31-96, cert. ef. 1-1-97; FWC 26-1997(Temp), f. 4-23-97, cert. ef. 5-17-97; FWC 75-1997, f. 12-31-97, cert. ef. 1-1-98; DFW 13-1998(Temp), f. & cert. ef. 2-26-98 thru 4-15-98; DFW 100-1998, f. 12-23-98, cert. ef. 1-1-99; DFW 5-1999(Temp), f. 2-5-99, cert. ef. 2-6-99 thru 2-19-99; DFW 8-1999(Temp), f. & cert. ef. 2-23-99 thru 4-15-99; DFW 37-1999(Temp), f. 5-24-99, cert. ef. 5-29-99 thru 6-5-99; DFW 43-1999(Temp), f. & cert. ef. 6-10-99 thru 6-13-99; DFW 45-1999(Temp), f. & cert. ef. 6-14-99 thru 6-20-99; DFW 96-1999, f. 12-27-99, cert. ef. 1-1-00; DFW 17-2000(Temp), f. 4-10-00, cert. ef. 4-16-00 thru 6-30-00; DFW 64-2000(Temp), f. 9-21-00, cert. ef. 9-22-00 thru 3-20-01; DFW 83-2000(Temp), f. 12-28-00, cert. ef. 1-1-01 thru 1-31-01; DFW 1-2001, f. 1-25-01, cert. ef. 2-1-01; DFW 5-2001(Temp), f. 2-22-01, cert. ef. 2-24-01 thru 4-15-01; DFW 39-2001(Temp) f. 5-23-01, cert. ef. 5-26-01 thru 7-1-01; DFW 40-2001(Temp) f. & cert. ef. 5-24-01 thru 11-20-01; DFW 45-2001(Temp), f. 6-1-01, cert. ef. 6-2-01 thru 7-31-01; DFW 49-2001(Temp), f. 6-19-01, cert. ef. 6-22-01 thru 7-31-01; DFW 70-2001, f. & cert. ef. 8-10-01; DFW 71-2001(Temp), f. 8-10-01, cert. ef. 9-1-01 thru 12-31-01; DFW 96-2001(Temp), f. 10-4-01, cert. ef. 12-1-01 thru 12-31-01; DFW 122-2001(Temp), f. & cert. ef. 12-31-01 thru 5-31-02; DFW 123-2001, f. 12-31-01, cert. ef. 1-1-02; DFW 26-2002, f. & cert. ef. 3-21-02; DFW 52-2002(Temp), f. 5-22-02, cert. ef. 5-26-02 thru 7-1-02; DFW 53-2002(Temp), f. 5-24-02, cert. ef. 5-26-02 thru 7-1-02; DFW 57-2002(Temp), f. & cert. ef. 5-30-02 thru 7-1-02; DFW 91-2002(Temp) f. 8-19-02, cert. ef 8-20-02 thru 11-1-02 (Suspended by DFW 101-2002(Temp), f. & cert. ef. 10-3-02 thru 11-1-02); DFW 130-2002, f. 11-21-02, cert. ef. 1-1-03; DFW 44-2003(Temp), f. 5-23-03, cert. ef. 5-28-03 thru 7-1-03; DFW 48-2003(Temp), f. & cert. ef. 6-5-03 thru 7-1-03; DFW 125-2003, f. 12-11-03, cert. ef. 1-1-04; DFW 40-2004(Temp), f. 5-7-04, cert. ef. 5-13-04 thru 7-1-04; DFW 46-2004(Temp), f. 5-21-04, cert. ef. 5-22-04 thru 7-1-04; DFW 55-2004(Temp), f. 6-16-04, cert. ef. 6-19-04 thru 7-5-04; DFW 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 42-2005(Temp), f. & cert. ef. 5-13-05 thru 9-1-05; DFW 61-2005(Temp), f. 6-22-05, cert. ef. 6-25-05 thru 7-4-05; Administrative correction 7-20-05; DFW 99-2005(Temp), f. 8-24-05, cert. ef. 8-26-05 thru 9-30-05; Administrative correction 10-19-05; DFW 136-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 28-2006(Temp), f. & cert. ef. 5-15-06 thru 6-30-06; DFW 33-2006(Temp), f. 5-24-06, cert. ef. 5-25-06 thru 6-30-06; Administrative correction 7-21-06; DFW 79-2006, f. 8-11-06, cert. ef. 1-1-07; DFW 12-2007(Temp), f. 2-28-07, cert. ef. 3-1-07 thru 8-27-07; DFW 30-2007(Temp), f. 5-9-07, cert. ef. 5-10-07 thru 9-30-07; DFW 34-2007(Temp), f. 5-25-07, cert. ef. 5-26-07 thru 9-30-07; Administrative correction 10-16-07; DFW 136-2007, f. 12-31-07, cert. ef. 1-1-08; DFW 56-2008(Temp), f. 5-30-08, cert. ef. 5-31-08 thru 6-30-08; DFW 76-2008(Temp), f. & cert. ef. 7-9-08 thru 9-1-08; DFW 156-2008, f. 12-31-08, cert. ef. 1-1-09; DFW 128-2009(Temp), f. 10-12-09, cert. ef. 10-18-09 thru 4-15-10; DFW 131-2009(Temp), f. 10-14-09, cert. ef. 10-18-09 thru 4-15-10; DFW 144-2009, f. 12-8-09, cert. ef. 1-1-10; DFW 54-2010(Temp), f. 5-6-10, cert. ef. 5-22-10 thru 9-1-10; DFW 95-2010(Temp), f. 7-1-10, cert. ef. 7-11-10 thru 9-1-10; DFW 102-2010(Temp), f. 7-20-10, cert. ef 7-25-10 thru 9-1-10; Administrative correction 9-22-10; DFW 171-2010, f. 12-30-10, cert. ef. 1-1-11; DFW 49-2011(Temp), f. 5-16-11, cert. ef. 5-28-11 thru 9-1-11; DFW 64-2011(Temp), f. 6-10-11, cert. ef. 6-13-11 thru 9-1-11; DFW 90-2011(Temp), f. & cert. ef. 7-11-11 thru 9-1-11; DFW 92-2011(Temp), f. 7-12-11, cert. ef. 7-16-11 thru 10-31-11; DFW 99-2011(Temp), f. 7-21-11, cert. ef. 7-23-11 thru 9-1-11; DFW 104-2011(Temp), f. 8-1-11, cert. ef. 8-7-11 thru 9-1-11; Administrative correction 9-23-11; DFW 163-2011, f. 12-27-11, cert. ef. 1-1-12; DFW 48-2012(Temp), f. 5-18-12, cert. ef. 5-23-12 thru 9-1-12; DFW 50-2012(Temp), f. 5-22-12, cert. ef. 5-24-12 thru 9-1-12; DFW 61-2012(Temp), f. & cert. ef. 6-11-12 thru 8-31-12; DFW 69-2012(Temp), f. 6-20-12, cert. ef. 6-22-12 thru 9-1-12; DFW 70-2012(Temp), f. 6-26-12, cert. ef. 6-27-12 thru 9-1-12; DFW 72-2012(Temp), f. 6-29-12, cert. ef. 7-1-12 thru 8-31-12; DFW 86-2012(Temp), f. 7-10-12, cert. ef. 7-15-12 thru 9-1-12; Administrative correction 9-20-12; DFW 149-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 153-2012(Temp), f. 12-28-12, cert. ef. 1-1-13 thru 4-30-13; DFW 31-2013(Temp), f. 5-14-13, cert. ef. 5-16-13 thru 6-30-13; DFW 39-2013(Temp), f. 5-22-13, cert. ef. 5-24-13 thru 11-19-13; DFW 46-2013(Temp), f. 5-30-13, cert. ef. 6-1-13 thru 11-26-13; DFW 62-2013(Temp), f. 6-26-13, cert. ef. 7-5-13 thru 12-31-13

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Rule Caption: Columbia River Treaty Indian Summer Chinook Commercial Fisheries Modified
Adm. Order No.: DFW 63-2013(Temp)
Filed with Sec. of State: 6-27-2013
Certified to be Effective: 6-29-13 thru 7-31-13
Notice Publication Date:
Rules Amended: 635-041-0076
Rules Suspended: 635-041-0076(T)
Subject: This amended rule authorizes a 2.5 day Treaty Indian Summer Chinook commercial gill net fishery in Zone 6 of the Columbia River. Further modifications restrict fishing in the ongoing Platform and Hook-and-line fisheries in all of Zone 6 and below Bonneville Dam to 5 days per week. Revisions are consistent with action taken

June 26, 2013 by the Columbia River Compact agencies of Oregon and Washington in cooperation with the Columbia River Treaty Tribes.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-041-0076
Summer Salmon Season

(1) Commercial sales of gill net caught fish from Zone 6 of the mainstem Columbia River is allowed beginning 6:00 a.m. Monday, July 1 through 6:00 p.m. Wednesday, July 3, 2013 (2.5 days).

(a) Salmon, steelhead, shad, yellow perch, bass, walleye, catfish and carp landed during any open gill net fishing period may be sold at any time or retained for subsistence purposes. Sturgeon may not be sold. However, white sturgeon between 43 and 54 inches in fork length taken from The Dalles and John Day pools and white sturgeon between 38 and 54 inches in fork length taken from the Bonneville Pool may be kept for subsistence purposes.

(b) Gear is restricted to gill nets. A seven-inch minimum mesh size restriction is in effect.

(2) Effective 12:01 a.m. Saturday, June 29 through 11:59 p.m. Wednesday, July 31, 2013, except Sundays and Mondays, salmon, steelhead, sockeye, coho, walleye, shad, carp, bass, catfish and yellow perch caught in platform hook-and-line fisheries in all of Zone 6 and tribal fisheries downstream of Bonneville Dam may be sold or retained for subsistence.

(a) Retention of sturgeon caught downstream of Bonneville Dam is prohibited and sturgeon may not be sold or retained for ceremonial or subsistence purposes.

(b) White sturgeon between 43 and 54 inches in fork length taken from The Dalles and John Day pools and white sturgeon between 38 and 54 inches in fork length taken from the Bonneville Pool may be kept for subsistence purposes only.

(3) Closed areas in Zone 6, except the Spring Creek sanctuary, are as set forth in OAR 635-041-0045 and remain in effect.

(4) Commercial sales of salmon, steelhead, walleye, shad, catfish, carp, bass and yellow perch caught in Yakama Nation tributary fisheries in the Yakima River; Klickitat River; Wind River; and Drano Lake are allowed for Yakama Nation members during those days and hours when these tributaries are open under lawfully enacted Yakama Nation fishing periods. Sturgeon retention is prohibited and may not be sold or retained for ceremonial or subsistence purposes.

Stat. Auth.: ORS 496.118 & 506.119
Stats. Implemented: ORS 506.109, 506.129 & 507.030
Hist.: DFW 5-2006, f. & cert. ef. 2-15-06; DFW 39-2006(Temp), f. & cert. ef. 6-8-06 thru 7-31-06; DFW 46-2006(Temp), f. & cert. ef. 6-20-06 thru 7-31-06; DFW 49-2006(Temp), f. 6-26-06, cert. ef. 6-27-06 thru 7-31-06; DFW 56-2006(Temp), f. 6-30-06, cert. ef. 7-3-06 thru 7-31-06; DFW 58-2006(Temp), f. 7-6-06, cert. ef. 7-10-06 thru 7-31-06; Administrative correction 8-22-06; DFW 46-2007(Temp), f. 6-15-07, cert. ef. 6-16-07 thru 9-13-07; DFW 49-2007(Temp), f. 6-22-07, cert. ef. 6-26-07 thru 9-13-07; DFW 53-2007(Temp), f. & cert. ef. 7-6-07 thru 7-31-07; Administrative correction 9-16-07; DFW 45-2008(Temp), f. 5-2-08, cert. ef. 5-5-08 thru 7-31-08; DFW 47-2008(Temp), f. 5-9-08, cert. ef. 5-11-08 thru 7-31-08; DFW 62-2008(Temp), f. 6-13-08, cert. ef. 6-16-08 thru 8-31-08; DFW 68-2008(Temp), f. 6-20-08, cert. ef. 6-21-08 thru 8-31-08; DFW 71-2008(Temp), f. 6-27-08, cert. ef. 6-28-08 thru 8-31-08; DFW 80-2008(Temp), f. & cert. ef. 7-10-08 thru 8-31-08; DFW 87-2008(Temp), f. & cert. ef. 7-25-08 thru 8-31-08; DFW 94-2008(Temp), f. & cert. ef. 8-14-08 thru 9-30-08; Administrative correction 10-21-08; DFW 50-2009(Temp), f. 5-14-09, cert. ef. 5-16-09 thru 7-31-09; DFW 56-2009(Temp), f. 5-26-09, cert. ef. 5-27-09 thru 7-31-09; DFW 71-2009(Temp), f. 6-15-09, cert. ef. 6-16-09 thru 7-31-09; DFW 76-2009(Temp), f. 6-26-09, cert. ef. 6-30-09 thru 7-31-09; DFW 82-2009(Temp), f. 7-6-09, cert. ef. 7-8-09 thru 7-31-09; DFW 84-2009(Temp), f. 7-13-09, cert. ef. 7-15-09 thru 7-31-09; Administrative correction 8-21-09; DFW 48-2010(Temp), f. 4-26-10, cert. ef. 4-27-10 thru 7-31-10; DFW 51-2010(Temp), f. & cert. ef. 4-29-10 thru 7-31-10; DFW 56-2010(Temp), f. 5-10-10, cert. ef. 5-11-10 thru 7-31-10; DFW 68-2010(Temp), f. 5-18-10, cert. ef. 5-19-10 thru 7-31-10; DFW 71-2010(Temp), f. 5-19-10, cert. ef. 5-21-10 thru 6-16-10; DFW 74-2010(Temp), f. & cert. ef. 6-2-10 thru 7-31-10; DFW 80-2010(Temp), f. 6-14-10, cert. ef. 6-16-10 thru 7-31-10; DFW 87-2010(Temp), f. 6-25-10, cert. ef. 6-29-10 thru 7-31-10; DFW 97-2010(Temp), f. 7-8-10, cert. ef. 7-13-10 thru 7-31-10; DFW 101-2010(Temp), f. 7-19-10, cert. ef. 7-20-10 thru 7-31-10; DFW 105-2010(Temp), f. 7-23-10, cert. ef. 7-26-10 thru 7-31-10; Administrative correction 8-18-10; DFW 43-2011(Temp), f. & cert. ef. 5-10-11 thru 10-31-11; DFW 66-2011(Temp), f. 6-14-11, cert. ef. 6-16-11 thru 10-31-11; DFW 75-2011(Temp), f. 6-24-11, cert. ef. 6-27-11 thru 10-31-11; DFW 84-2011(Temp), f. 7-1-11, cert. ef. 7-5-11 thru 10-31-11; DFW 88-2011(Temp), f. 7-8-11, cert. ef. 7-10-11 thru 10-31-11; DFW 94-2011(Temp), f. 7-14-11, cert. ef. 7-18-11 thru 10-31-11; DFW 98-2011(Temp), f. 7-20-11, cert. ef. 7-25-11 thru 10-31-11; Administrative correction, 11-18-11; DFW 66-2012(Temp), f. 6-14-12, cert. ef. 6-18-12 thru 7-31-12; DFW 81-2012(Temp), f. 6-29-12, cert. ef. 7-3-12 thru 8-31-12; [DFW 87-2012(Temp), f. 7-11-12, cert. ef. 7-12-12 thru 8-31-12; Temporary Suspended by DFW 94-2012(Temp), f. & cert. ef. 7-27-12 thru 10-31-12]; DFW 57-2013(Temp), f. 6-12-13, cert. ef. 6-16-13 thru 7-31-13; DFW 63-2013(Temp), f. 6-27-13, cert. ef. 6-29-13 thru 7-31-13

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Rule Caption: John Day Pool Closes to Retention of White Sturgeon Saturday, June 29, 2013
Adm. Order No.: DFW 64-2013(Temp)
Filed with Sec. of State: 6-27-2013
Certified to be Effective: 6-29-13 thru 10-31-13
Notice Publication Date:
Rules Amended: 635-023-0095
Rules Suspended: 635-023-0095(T)
Subject: This amended rule closes the recreational white sturgeon fishery in the John Day Pool of the Columbia River effective 12:01 a.m. Saturday, June 29, 2013. Modifications were made consistent with Joint State Action taken June 26, 2013 by Columbia River Compact agencies of the states of Oregon and Washington.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-023-0095
Sturgeon Season

(1) The **2013 Oregon Sport Fishing Regulations** provide requirements for the Columbia River Zone and the Snake River Zone. However, additional regulations may be adopted in this rule division from time to time, and, to the extent of any inconsistency, they supersede the **2013 Oregon Sport Fishing Regulations**.

(2) In 2013, the mainstem Columbia River from the Wauna powerlines (River Mile 40) upstream to Bonneville Dam, excluding the lower Willamette River upstream to Willamette Falls, Multnomah Channel, and the Gilbert River, is open to the retention of white sturgeon with a fork length of 38–54 inches, three days per week, Thursdays through Saturdays, during the following periods:

(a) January 1 through June 15; and

(b) October 19 through December 31.

(3) In 2013, the mainstem Columbia River from Wauna powerlines (River Mile 40) downstream to the mouth at Buoy 10, including Youngs Bay is open to the retention of white sturgeon seven days per week during the following periods:

(a) January 1 through April 30; and

(b) May 11 through June 20.

(4) During the fishing period as identified in subsection (3)(a) of this rule, only white sturgeon with a fork length of 38–54 inches may be retained.

(5) During the fishing periods as identified in subsection (3)(b) of this rule, only white sturgeon with a fork length of 41–54 inches may be retained.

(6) Effective April 1, 2013, the annual bag and possession limit for white sturgeon is two (2) fish.

(7) Angling for sturgeon is prohibited from:

(a) Bonneville Dam downstream 9 miles to a line crossing the Columbia River from Navigation Marker 82 on the Oregon shore westerly to a boundary marker on the Washington shore upstream of Fir Point from May 1 through August 31;

(b) Highway 395 Bridge upstream to McNary Dam; and

(c) From the west end of the grain silo at Rufus upstream to John Day Dam during May 1 through July 31.

(8) Angling is prohibited for all species from the upper and lower ends of Sand Island and corresponding markers on the Oregon shoreline (slough at Rooster Rock State Park) from January 1 through April 30.

(9) Effective February 11 through June 13; June 16 through June 20; and June 22 through December 31, 2013, retention of white sturgeon is prohibited in the mainstem Columbia River from Bonneville Dam upstream to The Dalles Dam (Bonneville Pool) including adjacent tributaries. Retention of white sturgeon between 38–54 inches in fork length is allowed in the area described in this section on June 14, 15, and 21, 2013 (3 days)

(10) Effective 12:01 a.m. Saturday, June 29, 2013 the retention of white sturgeon in the John Day Pool and adjacent tributaries is prohibited.

(11) The mainstem Columbia River from McNary Dam upstream to the Oregon-Washington border at river mile 309.5 is open to retention of white sturgeon with a fork length of 43–54 inches, seven days per week from February 1 through July 31.

(12) Retention of green sturgeon is prohibited all year in all areas.

(13) Catch-and-release angling is allowed year-round except as described above in sections (7)(a) through (7)(c) and (8) above.

(14) Effective January 1, 2014, the mainstem Columbia River from the mouth at Buoy 10 upstream to Bonneville Dam, including Oregon tributaries upstream to the mainline railroad bridges, is closed to the retention of white sturgeon.

Stat. Auth.: ORS 183.325, 506.109 & 506.119
Stats. Implemented: ORS 506.129 & 507.030

Hist.: DFW 129-2004(Temp), f. 12-23-04, cert. ef 1-1-05 thru 2-28-05; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 22-2005(Temp), f. 4-1-05, cert. ef. 4-30-05 thru 7-31-05; DFW 50-2005(Temp), f. 6-3-05, cert. ef. 6-11-05 thru 11-30-05; DFW 60-2005(Temp), f. 6-21-05, cert. ef. 6-24-05 thru 12-21-05; DFW 65-2005(Temp), f. 6-30-05, cert. ef. 7-10-05 thru 12-31-05; DFW 76-2005(Temp), f. 7-14-05, cert. ef. 7-18-05 thru 12-31-05; DFW 136-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 145-2005(Temp), f. 12-21-05, cert. ef. 1-1-06 thru 3-31-06; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 19-2006(Temp), f. 4-6-06, cert. ef. 4-8-06 thru 7-31-06; DFW 54-2006(Temp), f. 6-29-06, cert. ef. 7-1-06 thru 12-27-06; DFW 62-2006(Temp), f. 7-13-06, cert. ef. 7-24-06 thru 12-31-06; DFW 79-2006, f. 8-11-06, cert. ef. 1-1-07; DFW 131-2006(Temp), f. 12-20-06, cert. ef. 1-1-07 thru 6-29-07; DFW 7-2007(Temp), f. 1-31-07, cert. ef. 2-1-07 thru 7-30-07; DFW 9-2007, f. & cert. ef. 2-14-07; DFW 20-2007(Temp), f. 3-26-07, cert. ef. 3-28-07 thru 7-30-07; DFW 38-2007(Temp), f. & cert. ef. 5-31-07 thru 11-26-07; DFW 59-2007(Temp), f. 7-18-07, cert .ef. 7-29-07 thru 12-31-07; DFW 75-2007(Temp), f. 8-17-07, cert. ef. 8-18-07 thru 12-31-07; DFW 102-2007(Temp), f. 9-28-07, cert. ef. 10-1-07 thru 12-31-07; DFW 135-2007(Temp), f. 12-28-07, cert. ef. 1-1-08 thru 6-28-08; DFW 136-2007, f. 12-31-07, cert. ef. 1-1-08; DFW 8-2008, f. & cert. ef. 2-11-08; DFW 23-2008(Temp), f. 3-12-08, cert. ef. 3-15-08 thru 9-10-08; DFW 28-2008(Temp), f. 3-24-08, cert. ef. 3-26-08 thru 9-10-08; DFW 72-2008(Temp), f. 6-30-08, cert. ef. 7-10-08 thru 12-31-08; DFW 78-2008(Temp), f. 7-9-08, cert. ef. 7-12-08 thru 12-31-08; DFW 86-2008(Temp), f. & cert. ef. 7-25-08 thru 12-31-08; DFW 148-2008(Temp), f. 12-19-08, cert. ef. 1-1-09 thru 6-29-09; DFW 156-2008, f. 12-31-08, cert. ef. 1-1-09; DFW 18-2009, f. & cert. ef. 2-26-09; DFW 33-2009(Temp), f. 4-2-09, cert ef. 4-13-09 thru 10-9-09; DFW 63-2009(Temp), f. 6-3-09, cert. ef. 6-6-09 thru 10-9-09; DFW 83-2009(Temp), f. 7-8-09, cert. ef. 7-9-09 thru 12-31-09; DFW 86-2009(Temp), f. 7-22-09, cert. ef. 7-24-09 thru 12-31-09; DFW 144-2009, f. 12-8-09, cert. ef. 1-1-10; DFW 13-2010(Temp), f. 2-16-10, cert. ef. 2-21-10 thru 7-31-10; DFW 19-2010(Temp), f. 2-26-10, cert. ef. 3-1-10 thru 8-27-10; DFW 34-2010, f. 3-16-10, cert. ef. 4-1-10; DFW 49-2010(Temp), f. 4-27-10, cert. ef. 4-29-10 thru 7-31-10; DFW 50-2010(Temp), f. 4-29-10, cert. ef. 5-6-10 thru 11-1-10; DFW 88-2010(Temp), f. 6-25-10, cert. ef. 6-26-10 thru 7-31-10; DFW 91-2010(Temp), f. 6-29-10, cert. ef. 8-1-10 thru 12-31-10; DFW 99-2010(Temp), f. 7-13-10, cert. ef. 7-15-10 thru 12-31-10; DFW 165-2010(Temp), f. 12-28-10, cert. ef. 1-1-11 thru 6-29-11; DFW 171-2010, f. 12-30-10, cert. ef. 1-1-11; DFW 11-2011(Temp), f. 2-10-11, cert. ef. 2-11-1 thru 7-31-11; DFW 23-2011, f. & cert. ef. 3-21-11; DFW 26-2011(Temp), f. 4-5-11, cert. ef. 4-10-11 thru 9-30-11; DFW 74-2011(Temp), f. 6-24-11, cert. ef. 6-27-11 thru 7-31-11; DFW 87-2011(Temp), f. 7-8-11, cert. ef. 7-9-11 thru 7-31-11; DFW 96-2011(Temp), f. 7-20-11, cert. ef. 7-30-11 thru 12-31-11; DFW 129-2011(Temp), f. 9-15-11, cert. ef. 9-30-11 thru 12-31-11; DFW 163-2011, f. 12-27-11, cert. ef. 1-1-12; DFW 1-2012(Temp), f. & cert. ef. 1-5-12 thru 7-2-12; DFW 10-2012, f. & cert. ef. 2-7-12; DFW 16-2012(Temp), f. 2-14-12, cert. ef. 2-18-12 thru 7-31-12; DFW 44-2012(Temp), f. 5-1-12, cert. ef. 5-20-12 thru 7-31-12; DFW 73-2012(Temp), f. 6-29-12, cert. ef. 7-1-12 thru 8-31-12; DFW 97-2012(Temp), f. 7-30-12, cert. ef. 8-1-12 thru 12-31-12; DFW 129-2012(Temp), f. 10-3-12, cert. ef. 10-20-12 thru 12-31-12; DFW 140-2012(Temp), f. 10-31-12, cert. ef. 11-4-12 thru 12-31-12; DFW 152-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 154-2012(Temp), f. 12-28-12, cert. ef. 1-1-13 thru 2-28-13; DFW 12-2013(Temp), f. 2-12-13, cert. ef. 2-28-13 thru 7-31-13; DFW 23-2013(Temp), f. 3-20-13, cert. ef. 4-1-13 thru 9-27-13; DFW 47-2013(Temp), f. 5-30-13, cert. ef. 6-14-13 thru 9-30-13; DFW 59-2013(Temp), f. 6-19-13, cert. ef. 6-21-13 thru 10-31-13; DFW 64-2013(Temp), f. 6-27-13, cert. ef. 6-29-13 thru 10-31-13

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Rule Caption: Spring Pacific Ocean Sport Halibut All-Depth Season Closure from Cape Falcon to Humbug Mountain
Adm. Order No.: DFW 65-2013(Temp)
Filed with Sec. of State: 6-27-2013
Certified to be Effective: 6-28-13 thru 8-2-13
Notice Publication Date:
Rules Amended: 635-039-0085
Subject: Amended rule closes the all-depth spring sport fishery for Pacific halibut in the area between Cape Falcon and Humbug Mountain, Oregon at 11:59 p.m. on Friday, June 28 due to the projected attainment of the pre-season quota of 120,947 pounds on June 28, 2013. This rule is consistent with regulations previously implemented by the federal government and the International Pacific Halibut Commission for the 2013 Oregon sport fishery for Pacific halibut.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-039-0085
Halibut Seasons

(1) The Pacific halibut sport fishery in Oregon is regulated by the federal government and the International Pacific Halibut Commission (IPHC). OAR chapter 635, division 39 incorporates into Oregon Administrative Rules, by reference:

(a) Title 50 of the Code of Federal Regulations, Part 300, Subpart E (October 1, 2012 ed.), as amended; and

(b) Federal Register Vol. 77, No. 56, dated March 22, 2012 (77FR 16740).

(2) Therefore, persons must consult all publications referenced in this rule in addition to division 39 to determine applicable halibut fishing seasons.

(3) Effective 11:59 p.m., Friday, June 28, 2013 the Central Oregon Coast Subarea (Cape Falcon to Humbug Mountain) spring all-depth season is closed to the retention of Pacific halibut.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.138, 496.162, 506.036, 506.109, 506.119 & 506.129
Stats. Implemented: ORS 496.162 & 506.129
Hist.: DFW 56-2005, f. 6-21-05, cert. ef. 7-1-05; DFW 89-2005(Temp), f. & cert. ef. 8-12-05 thru 12-12-05; DFW 107-2005(Temp), f. 9-14-05, cert. ef. 9-15-05 thru 10-31-05; DFW 121-2005(Temp), f. 10-12-05, cert. ef. 10-18-05 thru 12-31-05; Administrative correction 1-19-06; DFW 34-2006(Temp), f. 5-25-06, cert. ef. 5-27-06 thru 8-3-06; Administrative correction 8-22-06; DFW 3-2007, f. & cert. ef. 1-12-07; DFW 35-2007(Temp), f. 5-25-07, cert. ef. 5-26-07 thru 8-2-07; DFW 67-2007(Temp), f. 8-9-07, cert. ef. 8-12-07 thru 9-30-07; DFW 76-2007(Temp), f. 8-17-07, cert. ef. 8-24-07 thru 9-30-07; DFW 84-2007(Temp), f. 9-5-07, cert. ef. 9-15-07 thru 9-30-07; DFW 87-2007(Temp), f. 9-10-07, cert. ef. 9-14-07 thru 10-28-07; DFW 90-2007(Temp), f. 9-19-07, cert ef. 9-20-07 thru 10-31-07; Administrative corection 11-17-07; DFW 57-2008(Temp), f. 5-30-08, cert. ef. 6-1-08 thru 7-31-08; DFW 81-2008(Temp), f. 7-11-08, cert. ef. 8-2-08 thru 9-30-08; DFW 92-2008(Temp), f. & cert. ef. 8-11-08 thru 9-30-08; DFW 101-2008(Temp), f.8-25-08, cert. ef. 8-29-08 thru 9-30-08; DFW 107-2008(Temp), f. 9-5-08, cert. ef. 9-7-08 thru 12-31-08; DFW 111-2008(Temp), f. & cert. ef. 9-16-08 thru 12-31-08; DFW 120-2008(Temp), f. 9-25-08, cert. ef. 9-27-08 thru 12-31-08; DFW 156-2008, f. 12-31-08, cert. ef. 1-1-09; DFW 39-2009, f. & cert. ef. 4-27-09; DFW 55-2009(Temp), f. & cert. ef. 5-22-09 thru 8-6-09; DFW 94-2009(Temp), f. 8-14-09, cert. ef. 8-16-09 thru 12-31-09; Administrative correction 1-25-10; DFW 32-2010, f. & cert. ef. 3-15-10; DFW 37-2010, f. 3-30-10, cert. ef. 4-1-10; DFW 100-2010(Temp), f. 7-15-10, cert. ef. 7-17-10 thru 10-31-10; DFW 118-2010(Temp), f. & cert. ef. 8-13-10 thru 10-31-10; Administrative correction 11-23-10; DFW 24-2011, f. & cert. ef. 3-22-11; DFW 58-2011(Temp), f. 5-27-11, cert. ef. 6-4-11 thru 8-4-11; DFW 82-2011(Temp), f. 6-30-11, cert. ef. 7-1-11 thru 8-4-11; DFW 85-2011(Temp), f. 7-5-11, cert. ef. 7-6-11 thru 10-31-11; DFW 114-2011(Temp), f. & cert. ef. 8-12-11 thru 10-31-11; DFW 135-2011(Temp), f. 9-21-11, cert. ef. 10-1-11 thru 12-31-11; DFW 39-2012, f. & cert. ef. 4-24-12; DFW 84-2012(Temp), f. & cert. ef. 7-5-12 thru 8-2-12; DFW 91-2012(Temp), f. 7-19-12, cert. ef. 7-22-12 thru 10-31-12; DFW 111-2012(Temp), f. 8-23-12, cert. ef. 8-24-12 thru 12-31-12; DFW 123-2012(Temp), f. 9-19-12, cert. ef. 9-24-12 thru 10-31-12; Administrative correction 11-23-12; DFW 65-2013(Temp), f. 6-27-13, cert. ef. 6-28-13 thru 8-2-13

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Rule Caption: 2013 Columbia River Summer Recreational Steelhead Fisheries Modified
Adm. Order No.: DFW 66-2013(Temp)
Filed with Sec. of State: 6-27-2013
Certified to be Effective: 6-27-13 thru 7-31-13
Notice Publication Date:
Rules Amended: 635-023-0128
Rules Suspended: 635-023-0128(T)
Subject: This amended rule modifies the summer recreational steelhead fishing season in the Columbia River. Modifications to regulations for 2013 conform to recent regulation changes developed through the Pacific Fishery Management Council/North of Falcon Process. Housekeeping and technical corrections to the regulations were made to ensure rule consistency.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-023-0128
Summer Sport Fishery

(1) The **2013 Oregon Sport Fishing Regulations** provide requirements for the Columbia River Zone and the Snake River Zone. However, additional regulations may be adopted in this rule division from time to time, and, to the extent of any inconsistency, they supersede the **2013 Oregon Sport Fishing Regulations**.

(2) Notwithstanding all other specifications and restrictions in the 2013 Oregon Sport Fishing Regulations:

(a) Effective June 16 through July 31 the mainstem Columbia River is open to the retention of adipose fin-clipped jack Chinook (12–24 inches in length) and adipose fin-clipped steelhead from the Astoria-Megler Bridge upstream to the Oregon/Washington border.

(b) Retention of sockeye salmon and adipose fin-clipped adult summer Chinook (longer than 24 inches in length) from the Astoria-Megler Bridge upstream to Bonneville Dam is allowed from June 16 through June 30, 2013 and from Bonneville Dam upstream to the Oregon/Washington border is allowed from June 16 through July 31, 2013.

(c) The combined daily bag limit for adult salmon and steelhead is two fish. All sockeye are considered adults in the daily limit. Only adipose fin-clipped Chinook and steelhead may be retained. The daily limit for jacks is five fish.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 496.162 & 506.129
Hist.: DFW 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 52-2005(Temp), f. 6-3-05, cert. ef. 6-16-05 thru 7-31-05; DFW 64-2005(Temp), f. 6-30-05, cert. ef. 7-1-05 thru 7-31-05; Administrative correction 8-17-05; DFW 26-2006(Temp), f. 4-20-06, cert. ef. 5-1-06 thru 10-27-06; DFW 79-2006, f. 8-11-06, cert. ef. 1-1-07; DFW 24-2007, f. 4-16-07, cert. ef. 5-1-07; DFW 51-2007(Temp), f. 6-29-07, cert. ef. 7-2-07 thru 7-31-07; DFW 136-2007, f. 12-31-07, cert. ef. 1-1-08; DFW 36-2008, f. 4-21-08, cert. ef. 5-1-08; DFW 61-2008(Temp), f. 6-13-08, cert. ef. 6-16-08 thru 7-31-08; DFW 68-2008(Temp), f. 6-20-08, cert. ef. 6-21-08 thru 8-31-08; DFW 71-2008(Temp), f. 6-27-08, cert. ef. 6-28-08 thru 8-31-08; Administrative correction 9-29-08; DFW 156-2008, f. 12-31-08, cert. ef. 1-1-09; DFW 52-2009, f. & cert. ef. 5-18-09; DFW 69-2009(Temp), f. 6-11-09, cert. ef. 6-16-09 thru 7-31-09; Administrative correction 8-21-09; DFW 144-2009, f. 12-8-09, cert. ef. 1-1-10; DFW 77-2010, f. 6-8-10, cert. ef. 6-16-10; DFW 88-2010(Temp), f. 6-25-10, cert. ef. 6-26-10 thru 7-31-10; Administrative correction 8-18-10; DFW 171-2010, f. 12-30-10, cert. ef. 1-1-11; DFW 65-2011(Temp), f. 6-14-11, cert. ef. 6-16-11 thru 7-31-11; DFW 95-2011(Temp), f. 7-15-11, cert. ef. 7-18-11 thru

7-31-11; Administrative correction 9-23-11; DFW 163-2011, f. 12-27-11, cert. ef. 1-1-12; DFW 64-2012(Temp), f. 6-12-12, cert. ef. 6-16-12 thru 7-31-12; [DFW 85-2012(Temp), f. 7-6-12, cert. ef. 7-9-12 thru 8-31-12; Temporary Suspended by DFW 100-2012(Temp), f. 7-31-12, cert. ef. 8-1-12 thru 12-31-12]; DFW 149-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 55-2013(Temp), f. 6-12-13, cert. ef. 6-16-13 thru 7-31-13; DFW 66-2013(Temp), f. & cert. ef. 6-27-13 thru 7-31-13

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Rule Caption: Additional Opportunity for Personal Use Harvest of Pacific Lamprey at Willamette Falls Allowed
Adm. Order No.: DFW 67-2013(Temp)
Filed with Sec. of State: 7-3-2013
Certified to be Effective: 7-11-13 thru 7-31-13
Notice Publication Date:
Rules Amended: 635-017-0090
Subject: This amended rule allows for one additional day for personal use harvest of Pacific lamprey, on Thursday, July 11, 2013, by individuals with the required permit. The season modification provides opportunity for harvest of lamprey that may become stranded due to the scheduled installation of water flow devices at Willamette Falls.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-017-0090
Inclusions and Modifications

(1) The **2013 Oregon Sport Fishing Regulations** provide requirements for the Willamette Zone. However, additional regulations may be adopted in this rule division from time to time and to the extent of any inconsistency, they supersede the **2013 Oregon Sport Fishing Regulations**.

(2) Pacific Lamprey Harvest:

(a) Pursuant to OAR 635-044-0130(1)(b), authorization from the Oregon Fish and Wildlife Commission must be in possession by individuals collecting or possessing Pacific lamprey for personal use. Permits are available from ODFW, 17330 SE Evelyn Street, Clackamas, OR 97015;

(b) Open fishing period is June 1 through July 31 from 7:00 A.M. to 6:00 P.M.; personal use harvest is permitted Friday through Monday each week. All harvest is prohibited Tuesday through Thursday, except personal use harvest is permitted on Thursday, July 11, 2013 from 7:00 a.m. to 6:00 p.m.;

(c) Open fishing area is the Willamette River at Willamette Falls on the east side of the falls only, excluding Horseshoe Area at the peak of the falls;

(d) Gear is restricted to hand or hand-powered tools only;

(e) Catch must be recorded daily on a harvest record card prior to leaving the open fishing area. Harvest record cards will be provided by ODFW. All harvest record cards must be returned to the ODFW Clackamas office by August 31 to report catch. Permit holders who do not return the harvest record cards by August 31 will be ineligible to receive a permit in the following year.

(f) Harvesters must allow sampling or enumeration of catches by ODFW personnel.

(3) Sandy River (Multnomah/Clackamas Co.) mainstem and tributaries upstream from ODFW markers at the mouth of the Salmon River, including the Salmon River:

(a) Open for adipose fin-clipped steelhead and non-adipose fin-clipped steelhead harvest July 1–August 31.

(b) Angling restricted to artificial flies and lures with a single point hook no larger than 1/2 inch gap (size 1) and multiple point hook no larger than 3/8 inch gap (size 4).

(c) No limit on size or number of brook trout taken. Catch limits on other trout species do not apply to brook trout.

(4) Effective January 1, 2013, the use of barbless hooks is required when angling for salmon, steelhead, or trout in the mainstem Willamette River downstream of Willamette Falls (including Multnomah Channel and the Gilbert River) and in the lower Clackamas River upstream to the Highway 99E Bridge.

Stat. Auth.: ORS 496.138, 496.146, 497.121 & 506.119
Stats. Implemented: ORS 496.004, 496.009, 496.162 & 506.129
Hist.: FWC 82-1993, f. 12-22-93, cert. ef. 1-1-94; FWC 3-1994, f. 1-25-94, cert. ef. 1-26-94; FWC 65-1994(Temp), f. 9-15-94, cert. ef. 9-17-94; FWC 86-1994(Temp), f. 10-31-94, cert. ef. 11-1-94; FWC 22-1995, f. 3-7-95, cert. ef. 3-10-95; FWC 32-1995, f. & cert. ef. 4-24-95; FWC 77-1995, f. 9-13-95, cert. ef. 1-1-96; FWC 14-1996, f. 3-29-96, cert. ef. 4-1-96; FWC 20-1996, f. & cert. ef. 4-29-96; FWC 22-1996(Temp), f. 5-9-96 & cert. ef. 5-10-96; FWC 72-1996, f. 12-31-96, cert. ef. 1-1-97; FWC 5-1997, f. & cert. ef. 2-4-97; FWC 13-1997, f. 3-5-97, cert. ef. 3-11-97; FWC 17-1997(Temp), f. 3-19-97, cert. ef. 4-1-97; FWC 24-1997(Temp), f. & cert. ef. 4-10-97; FWC 31-1997(Temp), f. 5-14-97, cert. ef. 5-15-97; FWC 39-1997(Temp), f. 6-17-97, cert. ef. 6-18-97; FWC 69-1997, f. & cert. ef. 11-6-97; FWC 75-1997, f. 12-31-97, cert. ef. 1-1-98; DFW 19-1998, f. & cert. ef. 3-12-98; DFW 28-1998(Temp), f. & cert. ef. 4-9-98 thru 4-24-98; DFW 31-1998(Temp), f. & cert. ef. 4-24-98 thru 7-31-98; DFW 33-1998(Temp), f. & cert. ef. 4-30-98 thru 5-15-98; DFW 34-1998, f. & cert. ef. 5-4-98; DFW 35-1998(Temp), f. & cert. ef. 5-10-98 thru 5-15-98; DFW 37-1998(Temp), f. & cert. ef. 5-15-98 thru 7-31-98; DFW 100-1998, f. 12-23-98, cert. ef. 1-1-99; DFW 15-1999, f. & cert. ef. 3-9-99; DFW 16-1999(Temp), f. & cert. ef. 3-10-99 thru 3-19-99; DFW 19-1999(Temp), f. & ef. 3-19-99 thru 4-15-99; DFW 27-1999(Temp), f. & cert. ef. 4-23-99 thru 10-20-99; DFW 30-1999(Temp), f. & cert. ef. 4-27-99 thru 5-12-99; DFW 35-1999(Temp), f. & cert. ef. 5-13-99 thru 7-31-99; DFW 39-1999(Temp), f. 5-26-99, cert. ef. 5-27-99 thru 7-31-99; DFW 78-1999, f. & cert. ef. 10-4-99; DFW 88-1999(Temp), f. 11-5-99, cert. ef. 11-6-99 thru 11-30-99; administrative correction 11-17-99; DFW 96-1999, f. 12-27-99, cert. ef. 1-1-00; DFW 13-2000, f. & cert. ef. 3-20-00; DFW 22-2000, f. 4-14-00, cert. ef. 4-16-00 thru 7-31-00; DFW 23-2000(Temp), f. 4-19-00, cert. ef. 4-22-00 thru 7-31-00; DFW 58-2000(Temp), f. & cert. ef. 9-1-00 thru 12-31-00; DFW 83-2000(Temp), f. 12-28-00, cert. ef. 1-1-01 thru 1-31-01; DFW 1-2001, f. 1-25-01, cert. ef. 2-1-01; DFW 6-2001, f. & cert. ef. 3-1-01; DFW 23-2001(Temp), f. & cert. ef. 4-23-01 thru 10-19-01; DFW 28-2001, f. & cert. ef. 5-1-01; DFW 40-2001(Temp) f. & cert. ef. 5-24-01 thru 11-20-01; DFW 46-2001(Temp) f. 6-8-01, cert. ef. 6-16-01 thru 12-13-01; DFW 70-2001, f. & cert. ef. 8-10-01; DFW 72-2001(Temp), f. 8-10-01, cert. ef. 8-16-01 thru 12-31-01; DFW 90-2001(Temp), f. 9-14-01, cert. ef. 9-15-01 thru 12-31-01; DFW 95-2001(Temp), f. 9-27-01, cert. ef. 10-20-01 thru 12-31-01; DFW 123-2001, f. 12-31-01, cert. ef. 1-1-02; DFW 5-2002(Temp) f. 1-11-02 cert. ef. 1-12-02 thru 7-11-02; DFW 26-2002, f. & cert. ef. 3-21-02; DFW 37-2002, f. & cert. ef. 4-23-02; DFW 42-2002, f. & cert. ef. 5-3-02; DFW 44-2002(Temp), f. 5-7-02, cert. ef. 5-8-02 thru 11-3-02; DFW 70-2002(Temp), f. 7-10-02 cert ef. 7-12-02 thru 12-31-02; DFW 91-2002(Temp) f. 8-19-02, cert. ef 8-20-02 thru 11-1-02 (Suspended by DFW 101-2002(Temp), f. & cert. ef. 10-3-02 thru 11-1-02); DFW 130-2002, f. 11-21-02, cert. ef. 1-1-03; DFW 16-2003(Temp), f. 2-27-03, cert. ef. 3-1-03 thru 7-1-03; DFW 42-2003, f. & cert. ef. 5-16-03; DFW 53-2003(Temp), f. 6-17-03, cert. ef. 6-18-03 thru 12-14-03; DFW 57-2003(Temp), f. & cert. ef. 7-8-03 thru 12-31-03; DFW 59-2003(Temp), f. & cert. ef. 7-11-03 thru 12-31-03; DFW 70-2003(Temp), f. & cert. ef. 7-23-03 thru 12-31-03; DFW 71-2003(Temp), f. 7-24-03, cert. ef. 7-25-03 thru 12-31-03; DFW 90-2003(Temp), f. 9-12-03 cert. ef. 9-13-03 thru 12-31-03; DFW 125-2003, f. 12-11-03, cert. ef. 1-1-04; DFW 33-2004, f. 4-22-04, cert ef. 5-1-04; DFW 48-2004(Temp), f. 5-26-04, cert. ef. 5-28-04 thru 11-23-04; DFW 69-2004(Temp), f. & cert. ef. 7-12-04 thru 11-23-04; DFW 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 24-2005, f. 4-15-05, cert. ef. 5-1-05; DFW 78-2005(Temp), f. 7-19-05, cert. ef. 7-21-05 thru 7-22-05; Administrative correction 8-17-05; DFW 136-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 36-2006(Temp), f. & cert. ef. 6-1-06 thru 9-30-06; DFW 79-2006, f. 8-11-06, cert. ef. 1-1-07; DFW 121-2006(Temp), f. & cert. ef. 10-20-06 thru 12-31-06; DFW 32-2007, f. 5-14-07, cert. ef. 6-1-07; DFW 65-2007(Temp), f. & cert. ef. 8-6-07 thru 10-31-07; DFW 105-2007(Temp), f. 10-4-07, cert. ef. 10-6-07 thru 11-30-07; Administrative correction 12-20-07; DFW 134-2007, f. 12-26-07, cert. ef. 1-1-08; DFW 136-2007, f. 12-31-07, cert. ef. 1-1-08; DFW 1-2008(Temp), f. & cert. ef. 1-9-08 thru 7-6-08; DFW 5-2008(Temp), f. 1-25-08, cert. ef. 2-1-08 thru 7-6-08; DFW 15-2008(Temp), f. 2-26-08, cert. ef. 3-1-08 thru 7-29-08; DFW 46-2008(Temp), f. 5-9-08, cert. ef. 5-12-08 thru 7-29-08; DFW 55-2008(Temp), f. 5-30-08, cert. ef. 6-2-08 thru 10-31-08; DFW 82-2008(Temp), f. 7-21-08, cert. ef. 7-29-08 thru 12-31-08; DFW 110-2008(Temp), f. 9-15-08, cert. ef. 9-17-08 thru 12-31-08; DFW 124-2008(Temp), f. 10-1-08, cert. ef. 10-2-08 thru 12-31-08; DFW 156-2008, f. 12-31-08, cert. ef. 1-1-09; DFW 9-2009(Temp), f. 2-13-09, cert. ef. 3-1-09 thru 8-15-09; DFW 15-2009, f. & cert. ef. 2-25-09; DFW 74-2009(Temp), f. 6-25-09, cert. ef. 6-30-09 thru 7-2-09; Administrative correction 7-21-09; DFW 103-2009(Temp), f. 8-27-09, cert. ef. 9-1-09 thru 12-31-09; DFW 118-2009(Temp), f. & cert. ef. 9-28-09 thru 12-31-09; DFW 123-2009(Temp), f. & cert. ef. 10-5-09 thru 12-31-09; DFW 144-2009, f. 12-8-09, cert. ef. 1-1-10; DFW 61-2010, f. & cert. ef. 5-14-10; DFW 62-2010(Temp), f. 5-14-10, cert. ef. 5-22-10 thru 11-17-10; DFW 84-2010(Temp), f. 6-17-10, cert. ef. 6-18-10 thru 10-31-10; DFW 94-2010(Temp), f. & cert. ef. 7-1-10 thru 10-31-10; DFW 96-2010(Temp), f. 7-7-10, cert. ef. 7-8-10 thru 10-31-10; DFW 123-2010(Temp), f. 8-26-10, cert. ef. 9-1-10 thru 12-31-10; DFW 134-2010(Temp), f. 9-22-10, cert. ef. 9-23-10 thru 12-31-10; DFW 171-2010, f. 12-30-10, cert. ef. 1-1-11; DFW 158-2011(Temp), f. 12-14-11, cert. ef. 1-1-12 thru 4-30-12; DFW 163-2011, f. 12-27-11, cert. ef. 1-1-12; DFW 21-2012, f. & cert. ef. 3-12-12; DFW 89-2012(Temp), f. 7-17-12, cert. ef. 7-26-12 thru 8-31-12; DFW 99-2012(Temp). f. 7-31-12, cert. ef. 8-1-12 thru 12-31-12; DFW 152-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 67-2013(Temp), f. 7-3-13, cert. ef. 7-11-13 thru 7-31-13

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Rule Caption: Allow Commercial Sales of Dressed Salmon and Steelhead by Columbia River Treaty Tribal Fishers
Adm. Order No.: DFW 68-2013(Temp)
Filed with Sec. of State: 7-3-2013
Certified to be Effective: 7-3-13 thru 12-30-13
Notice Publication Date:
Rules Amended: 635-006-0212, 635-006-0215, 635-006-0225
Subject: These amended rules allow commercial sales of gilled and gutted Columbia River salmon and steelhead caught by Treaty tribal members to wholesale fish dealers, canners, and buyers. Amendments also require wholesale fish dealers, canners, and buyers to report in round weights on the Fish Receiving Ticket using a conversion factor 1.15.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-006-0212
Fish Receiving Ticket — Salmon

(1) This regulation is in addition to, and not in lieu of the provisions contained in OAR 635-006-0210.

(2) Fish receiving tickets shall be completed at time of landing and the original copy forwarded within four consecutive days following the landing to the Oregon Department of Fish and Wildlife.

(3) For troll-caught salmon, fish receiving tickets shall show the number of days fished during the trip in which the salmon were caught.

(4) It is lawful for licensed wholesale fish dealers, canners, or buyers to purchase from tribal fishers, referred to in OAR 635-041-0005, gilled and gutted Columbia River salmon lawfully taken by treaty Indians during commercial fishing seasons. The licensed wholesale dealer must submit round weights on the Fish Receiving Ticket by multiplying the weights of gilled and gutted salmon by the conversion factor listed in OAR 635-006-0215 for tribal Columbia River salmon and steelhead.

Stat. Auth.: ORS 506.036, 506.109, 506.119, 506.129, 508.530 & 508.535
Stats. Implemented: ORS 506.109, 506.129, 508.025, 508.040 & 508.550
Hist.: FWC 142-1991, f. 12-31-91, cert. ef. 1-1-92; DFW 63-2003, f. & cert. ef. 7-17-03; DFW 31-2004, f. 4-22-04, cert. ef. 5-1-04; DFW 44-2006(Temp), f. & cert. ef. 6-19-06 thru 12-15-06; Administrative correction 12-16-06; DFW 79-2008(Temp) f. & cert. ef. 7-10-08 thru 12-31-08; Administrative correction 1-23-09; DFW 70-2009(Temp), f. 6-15-09, cert. ef. 6-16-09 thru 12-12-09; DFW 47-2010(Temp), f. 4-26-10, cert. ef. 4-27-10 thru 10-23-10; DFW 102-2011(Temp), f. 7-29-11, cert. ef. 8-1-11 thru 10-31-11; Administrative correction, 11-18-11; DFW 77-2012, f. 6-28-12, cert. ef. 7-1-12; DFW 83-2012(Temp), f. & cert. ef. 7-5-12 thru 12-31-12; Administrative correction, 2-1-13; DFW 68-2013(Temp), f. & cert. ef. 7-3-13 thru 12-30-13

635-006-0215
Monthly Remittance Report

(1) A monthly report is required of all licensed:

(a) Wholesale fish dealers, wholesale fish bait dealers, food fish canners, or shellfish canners receiving food fish or shellfish from licensed commercial fishers or bait fishers;

(b) Limited Fish Sellers selling food fish or shellfish.

(2) Except as provided in OAR 635-006-0220, the report is required even though no food fish or shellfish are received or sold during the calendar month covered by the report.

(3) The following information shall be included on the report:

(a) Fish dealer's name, license number, and address;

(b) Calendar month of the report;

(c) Serial numbers of all Fish Receiving Tickets issued during the month;

(d) Total pounds of all salmon and steelhead received or sold during the calendar month on which poundage fees are due. Salmon and steelhead may be reported as round weight, dressed head on or dressed head off;

(e) Total value of salmon and steelhead received or sold during the calendar month including fish eggs and parts;

(f) Total value of all other food fish and shellfish including eggs and parts;

(g) Total pounds in the round of all other species of food fish or shellfish received or sold during the calendar month on which taxes are due. When landed in a dressed condition, the following listed species may be converted to round weight for the purposes of completing monthly reports, by multiplying each applicable below-listed factor by the dressed weight of that species:

(A) Troll salmon:

(i) Gilled and gutted 1.15.

(ii) Gilled, gutted, and headed 1.30.

(B) Tribal Columbia River salmon and steelhead trout: Gilled and gutted 1.15.

(C) Halibut:

(i) Gilled and gutted 1.15.

(ii) Gilled, gutted, and headed 1.35.

(D) Sablefish, gutted and headed 1.60.

(E) Pacific whiting:

(i) Fillet 2.86.

(ii) Headed and gutted 1.56.

(F) Thresher shark 2.0.

(G) Lingcod:

(i) Gilled and gutted 1.1.

(ii) Gilled, gutted and headed 1.5.

(H) Spot prawn, tails 2.24.

(I) Groundfish, glazed:

(i) Conversion factors must be calculated for each landing for each species or species group categorized in OAR 635-006-0209 when there are 60 or greater individuals of a category in a single landing as follows:

(I) Weigh a sample of at least 20 glazed fish to obtain the glazed weight;

(II) Completely remove glaze from individual fish making up the sample;

(III) Re-weigh the sample to obtain the non-glazed weight;

(IV) Divide the non-glazed weight by the glazed weight to obtain the conversion factor;

(V) A separate conversion factor may be calculated for each size grade of a species, but may only be applied to landings of that size grade;

(VI) Documentation of this calculation must be retained with the dock receiving ticket.

(ii) A conversion factor of 0.95 must be applied when there are fewer than 60 individuals of any species or species group categorized in OAR 635-006-0209 in a single landing.

(h) Total value of food fish landed in another state but not taxed by that state;

(i) Total pounds in the round of all food fish landed in another state but not taxed by that state;

(j) Total fees due — in accordance with ORS 508.505 the fees are the value of the food fish at the point of landing multiplied by the following rates:

(A) All salmon and steelhead, 3.15 percent;

(B) Effective January 1, 2005, all black rockfish, blue rockfish and nearshore fish (as defined by ORS 506.011), 5.00 percent.

(C) Effective January 1, 2010, all other food fish (except tuna, as defined by ORS 508.505), 2.25 percent.

(D) All tuna (as defined by ORS 508.505), 1.09 percent.

(k) Signature of the individual completing the report.

(4) The monthly report and all landing fees due shall be sent to the Department on or before the 20th of each month for the preceding calendar month. Landing fees are delinquent if not received or postmarked within 20 days after the end of the calendar month. A penalty charge of $5 or five percent of the landing fees due, whichever is larger, shall be assessed along with a one percent per month interest charge on any delinquent landing fee payments.

Stat. Auth.: ORS 506.036, 506.109, 506.119, 506.129 & 508.530
Stats. Implemented: ORS 506.109, 506.129, 508.535, 508.505 & 508.550
Hist.: FC 246, f. 5-5-72, ef. 5-15-72; FC 274(74-6), f. 3-20-74, ef. 4-11-74; FWC 28, f. 11-28-75, ef. 1-1-76, Renumbered from 625-040-0140; FWC 48-1978, f. & ef. 9-27-78, Renumbered from 635-036-0585; FWC 17-1981(Temp), f. & ef. 5-22-81; FWC 25-1981(Temp), f. 7-8-81, ef. 7-15-81; FWC 27-1981, f. & ef. 8-14-81; FWC 1-1986, f. & ef. 1-10-86; FWC 4-1987, f. & ef. 2-6-87; FWC 99-1987, f. & ef. 11-17-87; FWC 142-1991, f. 12-31-91, cert. ef. 1-1-92; FWC 22-1992(Temp), f. 4-10-92, cert. ef. 4-13-92, FWC 53-1992, f. 7-17-92, cert. ef. 7-20-92; FWC 5-1993, f. 1-22-93, cert. ef. 1-25-93; DFW 38-1999, f. & cert. ef. 5-24-99; DFW 112-2003, f. & cert. ef. 11-14-03; DFW 31-2004, f. 4-22-04, cert. ef. 5-1-04; DFW 118-2005(Temp), f. & cert. ef. 10-10-05 thru 12-31-05; DFW 139-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 79-2008(Temp) f. & cert. ef. 7-10-08 thru 12-31-08; DFW 142-2008, f. & cert. ef. 11-21-08; DFW 70-2009(Temp), f. 6-15-09, cert. ef. 6-16-09 thru 12-12-09; DFW 73-2009(Temp), f. 6-24-09, cert. ef. 6-25-09 thru 12-21-09; Administrative correction 12-23-09; DFW 39-2010(Temp), f. 3-30-10, cert. ef. 4-1-10 thru 9-27-10; DFW 47-2010(Temp), f. 4-26-10, cert. ef. 4-27-10 thru 10-23-10; Administrative correction 11-23-10; DFW 157-2010, f. 12-6-10, cert. ef. 1-1-11; DFW 102-2011(Temp), f. 7-29-11, cert. ef. 8-1-11 thru 10-31-11; Administrative correction, 11-18-11; DFW 164-2011, f. 12-27-11, cert. ef. 1-1-12; DFW 77-2012, f. 6-28-12, cert. ef. 7-1-12; DFW 83-2012(Temp), f. & cert. ef. 7-5-12 thru 12-31-12; DFW 151-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 68-2013(Temp), f. & cert. ef. 7-3-13 thru 12-30-13

635-006-0225
Purchase, Record, Report, and Sale of Steelhead Trout and Walleye from Treaty Indian Fisheries

(1) Steelhead trout and walleye lawfully taken by treaty Indians during commercial fishing seasons may be purchased by licensed wholesale fish dealers, canners, or buyers pursuant to restrictions set forth in sections (2) through (5) of this rule. In addition, steelhead trout and walleye taken lawfully by treaty Indians during commercial fishing seasons may be purchased and/or possessed by any individual pursuant to restrictions set forth in section (6) of this rule.

(2) The wholesale fish dealer, canner, or buyer, shall at the time of purchase, enter the purchase of steelhead trout and walleye on a Department Columbia River Fish Receiving Ticket. Information required to be entered on the Fish Receiving Ticket shall be the same as required by OAR 635-006-0210 through 635-006-0212 for each purchase of food fish.

(3) The record keeping and reporting requirements for food fish as set forth in OAR 635-006-0200 through 635-006-0215 shall apply to all steelhead trout and walleye purchases. The round weights of all gilled and gutted steelhead trout must be converted by the licensed wholesale fish dealer, canner, or buyer by using the conversion factor listed in 635-006-0215 for Tribal Columbia River salmon and steelhead trout.

(4) In addition to the records required in connection with the purchase of steelhead trout, and walleye, a record of all sales of steelhead trout and walleye shall be maintained by licensed wholesale fish dealers, canners, or buyers for a period of three years and shall be subject to inspection by the Department, the Director's authorized agent or the Oregon State Police. Such record of sales shall include as a minimum:

(a) Name and address of each person to whom either steelhead or walleye are sold;

(b) Quantity in pounds of each sale identified as whole or round weight; and

(c) Date of each delivery.

(5) Steelhead trout and walleye taken lawfully by treaty Indians during commercial fishing seasons may be purchased from a treaty Indian and/or possessed by any individual so long as said fish are accompanied by a written document listing treaty Indian taker's name, tribal enrollment number, number of fish, approximate weight of each fish, date and location where taken, date of sale, and purchaser's name. It is *unlawful* for any individual other than a treaty Indian to sell steelhead trout or walleye. The provisions in this section (5) apply to individuals other than licensed wholesale fish dealers, canners and buyers.

Stat. Auth.: ORS 506.036, 506.109, 506.119, 508.530 & 509.031
Stats. Implemented: ORS 498.022, 506.109, 506.129, 508.535 & 508.550
Hist.: FWC 39, f. & ef. 1-23-76, Renumbered from 625-040-0150, Renumbered from 635-036-0595; FWC 142-1991, f. 12-31-91, cert. ef. 1-1-92; FWC 41-1995, f. 5-23-95, cert. ef. 5-24-95; FWC 51-1997(Temp), f. & cert. ef. 8-27-97; DFW 73-1998, f. & cert. ef. 8-28-98; DFW 32-2008(Temp), f. & cert. ef. 4-1-08 thru 9-27-08; DFW 79-2008(Temp) f. & cert. ef. 7-10-08 thru 12-31-08; DFW 142-2008, f. & cert. ef. 11-21-08; DFW 70-2009(Temp), f. 6-15-09, cert. ef. 6-16-09 thru 12-12-09; Administrative correction 12-23-09; DFW 47-2010(Temp), f. 4-26-10, cert. ef. 4-27-10 thru 10-23-10; Administrative correction 11-23-10; DFW 102-2011(Temp), f. 7-29-11, cert. ef. 8-1-11 thru 10-31-11; Administrative correction, 11-18-11; DFW 77-2012, f. 6-28-12, cert. ef. 7-1-12; DFW 83-2012(Temp), f. & cert. ef. 7-5-12 thru 12-31-12; DFW 101-2012, f. & cert. ef. 8-6-12; DFW 68-2013(Temp), f. & cert. ef. 7-3-13 thru 12-30-13

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Rule Caption: Columbia River Commercial Treaty Indian Summer Chinook Fisheries Modified
Adm. Order No.: DFW 69-2013(Temp)
Filed with Sec. of State: 7-5-2013
Certified to be Effective: 7-6-13 thru 7-31-13
Notice Publication Date:
Rules Amended: 635-041-0076
Rules Suspended: 635-041-0076(T)
Subject: This amended rule authorizes a 3.5 day Treaty Indian Summer Chinook commercial gill net fishery in Zone 6 of the Columbia River. Modifications authorize the ongoing Platform and Hook-and-line fisheries in Zone 6 and below Bonneville Dam to be conducted seven (7) days per week. Fish caught during open periods may be sold at any time or retained for subsistence. Revisions are consistent with action taken July 3, 2013 by the Columbia River Compact agencies, the states of Oregon and Washington in cooperation with the Columbia River Treaty Tribes.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-041-0076
Summer Salmon Season

(1) Commercial sales of gill net caught fish from Zone 6 of the mainstem Columbia River is allowed beginning 6:00 a.m. Monday, July 1 through 6:00 p.m. Wednesday, July 3, 2013 (2.5 days); and from 6:00 a.m. Monday, July 8 to 6:00 p.m. Thursday, July 11, 2013 (3.5 days).

(a) Salmon, steelhead, shad, yellow perch, bass, walleye, catfish and carp landed during any open gill net fishing period may be sold at any time or retained for subsistence purposes. Sturgeon may not be sold. However, white sturgeon between 43 and 54 inches in fork length taken from The Dalles and John Day pools and white sturgeon between 38 and 54 inches in fork length taken from the Bonneville Pool may be kept for subsistence purposes.

(b) Gear is restricted to gill nets. A seven-inch minimum mesh size restriction is in effect.

(2) Effective 12:01 a.m. Saturday, June 29 through 11:59 p.m. Wednesday, July 31, 2013, salmon, steelhead, sockeye, coho, walleye, shad, carp, bass, catfish and yellow perch caught in platform hook-and-line fisheries in all of Zone 6 and tribal fisheries downstream of Bonneville Dam may be sold or retained for subsistence.

(a) Retention of sturgeon caught downstream of Bonneville Dam is prohibited and sturgeon may not be sold or retained for ceremonial or subsistence purposes.

(b) White sturgeon between 43 and 54 inches in fork length taken from The Dalles and John Day pools and white sturgeon between 38 and 54 inches in fork length taken from the Bonneville Pool may be kept for subsistence purposes only.

(3) Closed areas in Zone 6, except the Spring Creek sanctuary, are as set forth in OAR 635-041-0045 and remain in effect.

(4) Commercial sales of salmon, steelhead, walleye, shad, catfish, carp, bass and yellow perch caught in Yakama Nation tributary fisheries in the Yakima River; Klickitat River; Wind River; and Drano Lake are allowed for Yakama Nation members during those days and hours when these tributaries are open under lawfully enacted Yakama Nation fishing periods. Sturgeon retention is prohibited and may not be sold or retained for ceremonial or subsistence purposes.

Stat. Auth.: ORS 496.118 & 506.119
Stats. Implemented: ORS 506.109, 506.129 & 507.030
Hist.: DFW 5-2006, f. & cert. ef. 2-15-06; DFW 39-2006(Temp), f. & cert. ef. 6-8-06 thru 7-31-06; DFW 46-2006(Temp), f. & cert. ef. 6-20-06 thru 7-31-06; DFW 49-2006(Temp), f. 6-26-06, cert. ef. 6-27-06 thru 7-31-06; DFW 56-2006(Temp), f. 6-30-06, cert. ef. 7-3-06 thru 7-31-06; DFW 58-2006(Temp), f. 7-6-06, cert. ef. 7-10-06 thru 7-31-06; Administrative correction 8-22-06; DFW 46-2007(Temp), f. 6-15-07, cert. ef. 6-16-07 thru 9-13-07; DFW 49-2007(Temp), f. 6-22-07, cert. ef. 6-26-07 thru 9-13-07; DFW 53-2007(Temp), f. & cert. ef. 7-6-07 thru 7-31-07; Administrative correction 9-16-07; DFW 45-2008(Temp), f. 5-2-08, cert. ef. 5-5-08 thru 7-31-08; DFW 47-2008(Temp), f. 5-9-08, cert. ef. 5-11-08 thru 7-31-08; DFW 62-2008(Temp), f. 6-13-08, cert. ef. 6-16-08 thru 8-31-08; DFW 68-2008(Temp), f. 6-20-08, cert. ef. 6-21-08 thru 8-31-08; DFW 71-2008(Temp), f. 6-27-08, cert. ef. 6-28-08 thru 8-31-08; DFW 80-2008(Temp), f. & cert. ef. 7-10-08 thru 8-31-08; DFW 87-2008(Temp), f. & cert. ef. 7-25-08 thru 8-31-08; DFW 94-2008(Temp), f. & cert. ef. 8-14-08 thru 9-30-08; Administrative correction 10-21-08; DFW 50-2009(Temp), f. 5-14-09, cert. ef. 5-16-09 thru 7-31-09; DFW 56-2009(Temp), f. 5-26-09, cert. ef. 5-27-09 thru 7-31-09; DFW 71-2009(Temp), f. 6-15-09, cert. ef. 6-16-09 thru 7-31-09; DFW 76-2009(Temp), f. 6-26-09, cert. ef. 6-30-09 thru 7-31-09; DFW 82-2009(Temp), f. 7-6-09, cert. ef. 7-8-09 thru 7-31-09; DFW 84-2009(Temp), f. 7-13-09, cert. ef. 7-15-09 thru 7-31-09; Administrative correction 8-21-09; DFW 48-2010(Temp), f. 4-26-10, cert. ef. 4-27-10 thru 7-31-10; DFW 51-2010(Temp), f. & cert. ef. 4-29-10 thru 7-31-10; DFW 56-2010(Temp), f. 5-10-10, cert. ef. 5-11-10 thru 7-31-10; DFW 68-2010(Temp), f. 5-18-10, cert. ef. 5-19-10 thru 7-31-10; DFW 71-2010(Temp), f. 5-19-10, cert. ef. 5-21-10 thru 6-16-10; DFW 74-2010(Temp), f. & cert. ef. 6-2-10 thru 7-31-10; DFW 80-2010(Temp), f. 6-14-10, cert. ef. 6-16-10 thru 7-31-10; DFW 87-2010(Temp), f. 6-25-10, cert. ef. 6-29-10 thru 7-31-10; DFW 97-2010(Temp), f. 7-8-10, cert. ef. 7-13-10 thru 7-31-10; DFW 101-2010(Temp), f. 7-19-10, cert. ef. 7-20-10 thru 7-31-10; DFW 105-2010(Temp), f. 7-23-10, cert. ef. 7-26-10 thru 7-31-10; Administrative correction 8-18-10; DFW 43-2011(Temp), f. & cert. ef. 5-10-11 thru 10-31-11; DFW 66-2011(Temp), f. 6-14-11, cert. ef. 6-16-11 thru 10-31-11; DFW 75-2011(Temp), f. 6-24-11, cert. ef. 6-27-11 thru 10-31-11; DFW 84-2011(Temp), f. 7-1-11, cert. ef. 7-5-11 thru 10-31-11; DFW 88-2011(Temp), f. 7-8-11, cert. ef. 7-10-11 thru 10-31-11; DFW 94-2011(Temp), f. 7-14-11, cert. ef. 7-18-11 thru 10-31-11; DFW 98-2011(Temp), f. 7-20-11, cert. ef. 7-25-11 thru 10-31-11; Administrative correction, 11-18-11; DFW 66-2012(Temp), f. 6-14-12, cert. ef. 6-18-12 thru 7-31-12; DFW 81-2012(Temp), f. 6-29-12, cert. ef. 7-3-12 thru 8-31-12; [DFW 87-2012(Temp), f. 7-11-12, cert. ef. 7-12-12 thru 8-31-12; Temporary Suspended by DFW 94-2012(Temp), f. & cert. ef. 7-27-12 thru 10-31-12]; DFW 57-2013(Temp), f. 6-12-13, cert. ef. 6-16-13 thru 7-31-13; DFW 63-2013(Temp), f. 6-27-13, cert. ef. 6-29-13 thru 7-31-13; DFW 69-2013(Temp), f. 7-5-13, cert. ef. 7-6-13 thru 7-31-13

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Rule Caption: 2013 Columbia River Recreational Summer Sockeye Fishery Opened
Adm. Order No.: DFW 70-2013(Temp)
Filed with Sec. of State: 7-11-2013
Certified to be Effective: 7-13-13 thru 7-31-13
Notice Publication Date:
Rules Amended: 635-023-0128
Rules Suspended: 635-023-0128(T)
Subject: This amended rule allows recreational harvest of sockeye salmon in the ongoing Columbia River summer fishery beginning July 13 through July 31, 2013. Revisions are consistent with action taken July 10, 2013 by the Columbia River Compact agencies, the states of Oregon and Washington.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-023-0128
Summer Sport Fishery

(1) The **2013 Oregon Sport Fishing Regulations** provide requirements for the Columbia River Zone and the Snake River Zone. However, additional regulations may be adopted in this rule division from time to time, and, to the extent of any inconsistency, they supersede the **2013 Oregon Sport Fishing Regulations**.

(2) Notwithstanding all other specifications and restrictions in the **2013 Oregon Sport Fishing Regulations**:

(a) Effective July 13 through July 31 the mainstem Columbia River is open to the retention of adipose fin-clipped jack Chinook (12-24 inches in length), adipose fin-clipped steelhead, and sockeye salmon from the Astoria-Megler Bridge upstream to Bonneville Dam.

(b) Retention of sockeye salmon, adipose fin-clipped steelhead and adipose fin-clipped adult summer Chinook (longer than 24 inches in length) is allowed from Bonneville Dam upstream to the Oregon/Washington border June 16 through July 31, 2013.

(c) The combined daily bag limit for adult salmon and steelhead is two fish. All sockeye are considered adults in the daily limit. Only adipose fin-clipped Chinook and steelhead may be retained. The daily limit for jacks is five fish.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 496.162 & 506.129
Hist.: DFW 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 52-2005(Temp), f. 6-3-05, cert. ef. 6-16-05 thru 7-31-05; DFW 64-2005(Temp), f. 6-30-05, cert. ef. 7-1-05 thru 7-31-05; Administrative correction 8-17-05; DFW 26-2006(Temp), f. 4-20-06, cert. ef. 5-1-06 thru 10-27-06; DFW 79-2006, f. 8-11-06, cert. ef. 1-1-07; DFW 24-2007, f. 4-16-07, cert. ef. 5-1-07;

DFW 51-2007(Temp), f. 6-29-07, cert. ef. 7-2-07 thru 7-31-07; DFW 136-2007, f. 12-31-07, cert. ef. 1-1-08; DFW 36-2008, f. 4-21-08, cert. ef. 5-1-08; DFW 61-2008(Temp), f. 6-13-08, cert. ef. 6-16-08 thru 7-31-08; DFW 68-2008(Temp), f. 6-20-08, cert. ef. 6-21-08 thru 8-31-08; DFW 71-2008(Temp), f. 6-27-08, cert. ef. 6-28-08 thru 8-31-08; Administrative correction 9-29-08; DFW 156-2008, f. 12-31-08, cert. ef. 1-1-09; DFW 52-2009, f. & cert. ef. 5-18-09; DFW 69-2009(Temp), f. 6-11-09, cert. ef. 6-16-09 thru 7-31-09; Administrative correction 8-21-09; DFW 144-2009, f. 12-8-09, cert. ef. 1-1-10; DFW 77-2010, f. 6-8-10, cert. ef. 6-16-10; DFW 88-2010(Temp), f. 6-25-10, cert. ef. 6-26-10 thru 7-31-10; Administrative correction 8-18-10; DFW 171-2010, f. 12-30-10, cert. ef. 1-1-11; DFW 65-2011(Temp), f. 6-14-11, cert. ef. 6-16-11 thru 7-31-11; DFW 95-2011(Temp), f. 7-15-11, cert. ef. 7-18-11 thru 7-31-11; Administrative correction 9-23-11; DFW 163-2011, f. 12-27-11, cert. ef. 1-1-12; DFW 64-2012(Temp), f. 6-12-12, cert. ef. 6-16-12 thru 7-31-12; [DFW 85-2012(Temp), f. 7-6-12, cert. ef. 7-9-12 thru 8-31-12; Temporary Suspended by DFW 100-2012(Temp), f. 7-31-12, cert. ef. 8-1-12 thru 12-31-12]; DFW 149-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 55-2013(Temp), f. 6-12-13, cert. ef. 6-16-13 thru 7-31-13; DFW 66-2013(Temp), f. & cert. ef. 6-27-13 thru 7-31-13; DFW 70-2013(Temp), f. 7-11-13, cert. ef. 7-13-13 thru 7-31-13

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Rule Caption: Columbia River Treaty Indian Summer Commercial Gill Net Season Authorized
Adm. Order No.: DFW 71-2013(Temp)
Filed with Sec. of State: 7-11-2013
Certified to be Effective: 7-15-13 thru 7-31-13
Notice Publication Date:
Rules Amended: 635-041-0076
Rules Suspended: 635-041-0076(T)
Subject: This amended rule authorizes a 3.5 day Treaty Indian Summer Chinook commercial gill net fishery in Zone 6 of the Columbia River from 6:00 a.m. Monday, July 15 through 6:00 p.m. Thursday, July 18, 2013. Fish caught during this open period may be sold at any time or retained for subsistence. Revisions are consistent with action taken July 10, 2013 by the Columbia River Compact agencies, the states of Oregon and Washington in cooperation with the Columbia River Treaty Tribes.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-041-0076
Summer Salmon Season

(1) Commercial sales of gill net caught fish from Zone 6 of the mainstem Columbia River is allowed beginning 6:00 a.m. Monday, July 1 through 6:00 p.m. Wednesday, July 3, 2013 (2.5 days); from 6:00 a.m. Monday, July 8 to 6:00 p.m. Thursday, July 11, 2013 (3.5 days); and from 6:00 a.m. Monday, July 15 to 6:00 p.m. Thursday, July 18, 2013 (3.5 days).

(a) Salmon, steelhead, shad, yellow perch, bass, walleye, catfish and carp landed during any open gill net fishing period may be sold at any time or retained for subsistence purposes. Sturgeon may not be sold. However, white sturgeon between 43 and 54 inches in fork length taken from The Dalles and John Day pools and white sturgeon between 38 and 54 inches in fork length taken from the Bonneville Pool may be kept for subsistence purposes.

(b) Gear is restricted to gill nets. A seven-inch minimum mesh size restriction is in effect.

(2) Effective 12:01 a.m. Saturday, June 29 through 11:59 p.m. Wednesday, July 31, 2013, salmon, steelhead, sockeye, coho, walleye, shad, carp, bass, catfish and yellow perch caught in platform hook-and-line fisheries in all of Zone 6 and tribal fisheries downstream of Bonneville Dam may be sold or retained for subsistence.

(a) Retention of sturgeon caught downstream of Bonneville Dam is prohibited and sturgeon may not be sold or retained for ceremonial or subsistence purposes.

(b) White sturgeon between 43 and 54 inches in fork length taken from The Dalles and John Day pools and white sturgeon between 38 and 54 inches in fork length taken from the Bonneville Pool may be kept for subsistence purposes only.

(3) Closed areas in Zone 6, except the Spring Creek sanctuary, are as set forth in OAR 635-041-0045 and remain in effect.

(4) Commercial sales of salmon, steelhead, walleye, shad, catfish, carp, bass and yellow perch caught in Yakama Nation tributary fisheries in the Yakima River; Klickitat River; Wind River; and Drano Lake are allowed for Yakama Nation members during those days and hours when these tributaries are open under lawfully enacted Yakama Nation fishing periods. Sturgeon retention is prohibited and may not be sold or retained for ceremonial or subsistence purposes.

Stat. Auth.: ORS 496.118 & 506.119
Stats. Implemented: ORS 506.109, 506.129 & 507.030
Hist.: DFW 5-2006, f. & cert. ef. 2-15-06; DFW 39-2006(Temp), f. & cert. ef. 6-8-06 thru 7-31-06; DFW 46-2006(Temp), f. & cert. ef. 6-20-06 thru 7-31-06; DFW 49-2006(Temp), f. 6-26-06, cert. ef. 6-27-06 thru 7-31-06; DFW 56-2006(Temp), f. 6-30-06, cert. ef. 7-3-06 thru 7-31-06; DFW 58-2006(Temp), f. 7-6-06, cert. ef. 7-10-06 thru 7-31-06; Administrative correction 8-22-06; DFW 46-2007(Temp), f. 6-15-07, cert. ef. 6-16-07 thru 9-13-07; DFW 49-2007(Temp), f. 6-22-07, cert. ef. 6-26-07 thru 9-13-07; DFW 53-2007(Temp), f. & cert. ef. 7-6-07 thru 7-31-07; Administrative correction 9-16-07; DFW 45-2008(Temp), f. 5-2-08, cert. ef. 5-5-08 thru 7-31-08; DFW 47-2008(Temp), f. 5-9-08, cert. ef. 5-11-08 thru 7-31-08; DFW 62-2008(Temp), f. 6-13-08, cert. ef. 6-16-08 thru 8-31-08; DFW 68-2008(Temp), f. 6-20-08, cert. ef. 6-21-08 thru 8-31-08; DFW 71-2008(Temp), f. 6-27-08, cert. ef. 6-28-08 thru 8-31-08; DFW 80-2008(Temp), f. & cert. ef. 7-10-08 thru 8-31-08; DFW 87-2008(Temp), f. & cert. ef. 7-25-08 thru 8-31-08; DFW 94-2008(Temp), f. & cert. ef. 8-14-08 thru 9-30-08; Administrative correction 10-21-08; DFW 50-2009(Temp), f. 5-14-09, cert. ef. 5-16-09 thru 7-31-09; DFW 56-2009(Temp), f. 5-26-09, cert. ef. 5-27-09 thru 7-31-09; DFW 71-2009(Temp), f. 6-15-09, cert. ef. 6-16-09 thru 7-31-09; DFW 76-2009(Temp), f. 6-26-09, cert. ef. 6-30-09 thru 7-31-09; DFW 82-2009(Temp), f. 7-6-09, cert. ef. 7-8-09 thru 7-31-09; DFW 84-2009(Temp), f. 7-13-09, cert. ef. 7-15-09 thru 7-31-09; Administrative correction 8-21-09; DFW 48-2010(Temp), f. 4-26-10, cert. ef. 4-27-10 thru 7-31-10; DFW 51-2010(Temp), f. & cert. ef. 4-29-10 thru 7-31-10; DFW 56-2010(Temp), f. 5-10-10, cert. ef. 5-11-10 thru 7-31-10; DFW 68-2010(Temp), f. 5-18-10, cert. ef. 5-19-10 thru 7-31-10; DFW 71-2010(Temp), f. 5-19-10, cert. ef. 5-21-10 thru 6-16-10; DFW 74-2010(Temp), f. & cert. ef. 6-2-10 thru 7-31-10; DFW 80-2010(Temp), f. 6-14-10, cert. ef. 6-16-10 thru 7-31-10; DFW 87-2010(Temp), f. 6-25-10, cert. ef. 6-29-10 thru 7-31-10; DFW 97-2010(Temp), f. 7-8-10, cert. ef. 7-13-10 thru 7-31-10; DFW 101-2010(Temp), f. 7-19-10, cert. ef. 7-20-10 thru 7-31-10; DFW 105-2010(Temp), f. 7-23-10, cert. ef. 7-26-10 thru 7-31-10; Administrative correction 8-18-10; DFW 43-2011(Temp), f. & cert. ef. 5-10-11 thru 10-31-11; DFW 66-2011(Temp), f. 6-14-11, cert. ef. 6-16-11 thru 10-31-11; DFW 75-2011(Temp), f. 6-24-11, cert. ef. 6-27-11 thru 10-31-11; DFW 84-2011(Temp), f. 7-1-11, cert. ef. 7-5-11 thru 10-31-11; DFW 88-2011(Temp), f. 7-8-11, cert. ef. 7-10-11 thru 10-31-11; DFW 94-2011(Temp), f. 7-14-11, cert. ef. 7-18-11 thru 10-31-11; DFW 98-2011(Temp), f. 7-20-11, cert. ef. 7-25-11 thru 10-31-11; Administrative correction, 11-18-11; DFW 66-2012(Temp), f. 6-14-12, cert. ef. 6-18-12 thru 7-31-12; DFW 81-2012(Temp), f. 6-29-12, cert. ef. 7-3-12 thru 8-31-12; [DFW 87-2012(Temp), f. 7-11-12, cert. ef. 7-12-12 thru 8-31-12; Temporary Suspended by DFW 94-2012(Temp), f. & cert. ef. 7-27-12 thru 10-31-12]; DFW 57-2013(Temp), f. 6-12-13, cert. ef. 6-16-13 thru 7-31-13; DFW 63-2013(Temp), f. 6-27-13, cert. ef. 6-29-13 thru 7-31-13; DFW 69-2013(Temp), f. 7-5-13, cert. ef. 7-6-13 thru 7-31-13; DFW 71-2013(Temp), f. 7-11-13, cert. ef. 7-15-13 thru 7-31-13

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Rule Caption: Non-Indian Columbia River Commercial Summer Chinook Gillnet Fishery Authorized
Adm. Order No.: DFW 72-2013(Temp)
Filed with Sec. of State: 7-11-2013
Certified to be Effective: 7-15-13 thru 7-31-13
Notice Publication Date:
Rules Amended: 635-042-0027
Rules Suspended: 635-042-0027(T)
Subject: This amended rule authorizes a non-Indian commercial gillnet fishery for summer Chinook salmon in the Columbia River mainstem consistent with provisions of the US v. Oregon management agreement. Modifications allow an 8 hour fishing period in the mainstem Columbia River beginning at 9:00 p.m. Monday, July 15 through 5:00 a.m. Tuesday, July 16, 2013. Fishing is authorized in all of Zones 1 through 5. Rule modifications are consistent with action taken July 10, 2013 by the Columbia River Compact agencies of Oregon and Washington.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-042-0027
Summer Salmon Season

(1) Chinook and sockeye salmon, white sturgeon and shad may be taken by drift gill net for commercial purposes in Zones 1 thru 5, from 9:00 p.m. Monday, July 15 to 5:00 a.m. Tuesday, July 16, 2013 (8 hours).

(2) It is *unlawful* to use a gill net having a mesh size less than 8 inches. Nets not specifically authorized for use in this fishery may be onboard the vessel if properly stored. A properly stored net is defined as a net on a drum that is fully covered by a tarp (canvas or plastic) and bound with a minimum of ten revolutions of rope with a diameter of 3/8 (0.375) inches or greater.

(3) A maximum of two (2) white sturgeon may be possessed or sold by each participating vessel during each calendar week (Sunday through Saturday) that the fishery is open. Limit applies to the mainstem only as the Youngs Bay Select Area remains open under a two (2) white sturgeon weekly retention limit.

(4) All steelhead must be released immediately.

(5) Closed waters, as described in OAR 635-042-0005 for Elokomin-A, Cowlitz River, Kalama A, Lewis A, Washougal River and Sandy River sanctuaries are in effect during open fishing periods as applicable.

Stat. Auth.: ORS 496.118, 506.109 & 506.129
Stats. Implemented: ORS 506.119 & 507.030
Hist.: DFW 5-2006, f. & cert. ef. 2-15-06; DFW 47-2006(Temp), f. 6-20-06, cert. ef. 6-26-06 thru 7-31-06; DFW 51-2006(Temp), f. & cert. ef. 6-29-06 thru 7-31-06; DFW 57-2006(Temp), f. 7-5-06, cert. ef. 7-6-06 thru 7-31-06; DFW 63-2006(Temp), f. 7-14-2006, cert. ef. 7-16-06 thru 7-31-06; DFW 68-2006(Temp), f. 7-28-06, cert. ef. 7-30-06 thru 7-31-06; Administrative correction 8-22-06; DFW 45-2007(Temp), f. 6-15-07, cert. ef. 6-25-07 thru 7-31-07; DFW 52-2007(Temp), f. & cert. ef. 7-6-07 thru 7-31-07; DFW 63-2008(Temp), f. 6-13-08, cert. ef. 6-24-08 thru 7-31-08; DFW 68-2008(Temp), f. 6-20-08, cert. ef. 6-21-08 thru 8-31-08; DFW 75-2008(Temp), f. 7-3-08, cert. ef. 7-7-08 thru 7-31-08; Administrative correction 8-21-08; DFW 72-2009(Temp), f. 6-15-09, cert. ef. 6-18-09 thru 7-31-09;

Administrative correction 8-21-09; DFW 81-2010(Temp), f. 6-14-10, cert. ef. 6-17-10 thru 7-31-10; Administrative correction 8-18-10; DFW 67-2011(Temp), f. 6-14-11, cert. ef. 6-16-11 thru 7-31-11; Administrative correction 9-23-11; DFW 67-2012(Temp), f. 6-14-12, cert. ef. 6-17-12 thru 7-31-12; Administrative correction, 8-27-12; DFW 56-2013(Temp), f. 6-12-13, cert. ef. 6-16-13 thru 7-31-13; DFW 72-2013(Temp), f. 7-11-13, cert. ef 7-15-13 thru 7-31-13

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Rule Caption: Amend rules relating to Oregon Wolf Conservation and Management Plan
Adm. Order No.: DFW 73-2013
Filed with Sec. of State: 7-12-2013
Certified to be Effective: 7-12-13
Notice Publication Date: 6-1-2013
Rules Amended: 635-110-0010, 635-110-0020
Rules Repealed: 635-110-0010(T), 635-110-0020(T)
Subject: Amend rules to change process and thresholds for use of lethal force to respond to chronic wolf depredation.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-110-0010
Harassment and Take of Wolves during Phase I (Conservation)

NOTE: As of October 1, 2010, these rules are pre-empted by the endangered status of the gray wolf under the federal Endangered Species Act. Once federal protections are reduced to a level below that of Oregon law, these rules will govern harassment and take of wolves in Oregon.

(1) This rule describes the types of harassment and take of wolves allowed by persons outside ODFW (or ODFW or Wildlife Services acting as their agent) during Phase I — (Conservation: 0–4 breeding pairs) as called for in chapter III of the Oregon Wolf Conservation and Management Plan. Other chapters of the Plan authorize ODFW to take wolves for other specified wildlife management purposes. For OAR 635-110-0010, 635-110-0020 and 635-110-0030, "livestock" means horses, jackasses, cattle, llamas, alpacas, sheep, goats, swine, domesticated fowl, any fur-bearing animal bred and maintained (commercially or otherwise) within pens, cages and hutches, bison and working dogs. "Working dogs" means guarding dogs and herding dogs.

(2) Non-injurious harassment.

(a) Subject to the conditions specified in paragraph (c), the following persons may use non-injurious harassment against wolves without a permit:

(A) Livestock producers (or their agents) on land they own or lawfully occupy; or

(B) Grazing permittees legally using public land under valid livestock grazing allotments.

(b) Non-injurious harassment means scaring off a wolf (or wolves) without doing bodily harm, and includes (but is not limited to) firing shots in the air, making loud noises or otherwise confronting the wolf (or wolves).

(c) Non-injurious harassment is allowed without a permit under this rule only if:

(A) The wolf (or wolves) is in the act of testing or chasing livestock, is attempting to test or chase livestock or is in close proximity of livestock;

(B) The person encounters the wolf (or wolves) unintentionally (i.e., the person is not stalking or searching for wolves);

(C) The harassment in fact does not result in injury to the wolf (or wolves); and

(D) The harassment is reported to ODFW within 48 hours.

(d) Any non-injurious harassment that does not meet each requirement of this rule requires a permit in advance from ODFW.

(3) Non-lethal injurious harassment.

(a) Subject to the conditions specified in paragraph (c), in addition to state or state authorized agents, the following persons may use non-lethal injurious harassment against wolves by permit:

(A) Livestock producers (or their agents) on land they own or lawfully occupy;

(B) Grazing permittees legally using public land under valid livestock grazing allotments.

(b) Non-lethal injurious harassment means scaring off a wolf (or wolves) without killing but with some injury to the wolf. Wolves may be pursued (unintentional encounters are not required).

(c) Non-lethal injurious harassment is allowed by permit from ODFW only if:

(A) ODFW confirms wolf depredation on livestock or other wolf-livestock conflict in the area. "Other wolf-livestock conflict" means loitering near, testing, chasing, or otherwise disrupting livestock;

(B) The applicant confers with ODFW to determine the most effective harassment method;

(C) ODFW considers the location of known den sites;

(D) The harassment in fact does not result in the death of a wolf;

(E) No identified circumstance exists that attracts wolf/livestock conflict; and

(F) The harassment is reported to ODFW within 48 hours.

(d) Permits for non-lethal injurious harassment remain valid for the livestock grazing season in which issued, provided the livestock operator complies with all applicable laws, including permit conditions. The agency shall inform harassment permit holders of non-lethal methods for minimizing wolf-livestock conflict and provide assistance upon request. Receiving future lethal control permits is contingent upon documentation of efforts to use non-lethal methods.

(4) Relocation. ODFW will authorize relocation by state personnel when a wolf (or wolves) becomes inadvertently involved in a situation, or is present in an area, that could result in conflict with humans or harm to the wolf, provided that ODFW has no reason to believe that the wolf actually attacked or killed livestock or pets. The relocation will be designed to prevent conflict with humans or reduce the possibility of harm to the wolf. The wolf (or wolves) would be relocated to suitable habitat at the direction of ODFW.

(5) Lethal take of wolves in the act of attacking livestock.

(a) Subject to the conditions specified in paragraph (c) and with a permit from ODFW, the following persons may use lethal force against wolves in the act of attacking livestock:

(A) Livestock producers (or their agents) on land they own or lawfully occupy; or

(B) Grazing permittees using public land.

(b) A wolf is "in the act of attacking livestock" if it is biting, wounding or killing livestock.

(c) Lethal force is allowed by permit from ODFW only if:

(A) ODFW confirms that wolves previously have wounded or killed livestock in the area and efforts to prevent or resolve the problem have been deemed ineffective;

(B) The wolf is seen in the act of attacking, not testing or scavenging;

(C) There is fresh evidence of the attack (e.g., visible wounds, tracks demonstrating a chase occurred);

(D) The wolf carcass is not removed or disturbed;

(E) The use of lethal force is reported to ODFW or Wildlife Services within 24 hours;

(F) No identified circumstance exists that attracts wolf/livestock conflict;

(G) ODFW confirms that the wound was caused by a wolf (or wolves): and

(H) Throughout the term of the permit, the permit holder implements non-lethal actions to minimize or avoid wolf-livestock conflict.

NOTE: The Oregon Wolf Conservation and Management Plan calls for allowing lethal take of wolves in this situation without a permit on private land. However, the Plan recognizes that because current statute requires a permit, implementing this portion of the Plan depends upon amendment of the statute by the legislature. Should the legislature make that statutory change, the Commission will amend this rule to allow for take without permit.

(6) Lethal take to address chronic livestock depredation. ODFW may authorize its personnel or authorized agents to use lethal force on a wolf or wolves it reasonably believes are responsible for chronic depredation upon livestock where each of the conditions in subsections (7) through (10) of this rule is satisfied. ODFW shall limit lethal force to the wolf or wolves it deems necessary to address the chronic depredation situation

(7) Conditions for Lethal Take by ODFW. ODFW's discretionary authority for use of lethal force pursuant to this rule may be exercised if ODFW:

(a) Designates an Area of Known Wolf Activity, the boundary of which may be adjusted as new data or information become available;

(b) Upon the designation of an Area of Known Wolf Activity, coordinates in a timely manner with potentially affected livestock producers and other relevant interests to provide information on:

(A) The provisions of the Oregon Wolf Conservation & Management Plan and associated rules,

(B) The current state of knowledge of wolf behavior, management, and conservation,

(C) Procedures for documenting and reporting wolf activity to ODFW, including depredations upon livestock, and

(D) Non-lethal measures, incentives and available assistance aimed at minimizing conflicts between wolves and livestock or domestic animals in the area of known wolf activity;

(c) Confirms an incident of depredation of livestock by a wolf or wolves;

(d) Within 14 working days of ODFW's confirmation of the first incident of depredation in an area:

(A) Designates an Area of Depredating Wolves, the boundary of which may be adjusted as new data or information become available;

(B) Concurrent with the designation of an Area of Depredating Wolves, prepares and publicly discloses an area-specific wolf-livestock conflict deterrence plan in coordination with potentially affected landowners, livestock producers and other relevant interests. The plan shall identify appropriate non-lethal measures according to which measures are likely to be most effective in a given circumstance, including the nature of the livestock operations, habitat, and landscape conditions specific to the area, as well as particular times of the year or period of livestock production. The plan shall be based on information compiled by ODFW before and/or during the planning effort on potentially successful conflict deterrence techniques, scientific research, and available financial resources and/or partnerships that may aid in the successful implementation of the plan. ODFW may update an area-specific conflict deterrence plan as new data become available.

(e) Confirms a total of at least 4 qualifying incidents of depredation of livestock within the previous 6 months by the same wolf or wolves.

(f) Issues and makes publicly available, prior to the exercise of lethal force, a written determination by the ODFW Director or director's designee to use lethal force to address a specified situation of chronic depredation, along with supporting findings that:

(A) The conditions of sections (7), (8), and (9) of this rule have been satisfied;

(B) Livestock producers in the Area of Depredating Wolves have worked to reduce wolf-livestock conflict and are in compliance with wolf protection laws and the conditions of any harassment or take permits.

(C) The situation of wolf depredation upon livestock in the Area of Depredating Wolves is likely to remain chronic despite the use of additional non-lethal conflict deterrence measures; and

(D) The wolf or wolves identified for removal are those ODFW believes to be associated with the qualifying depredations, the removal of which ODFW believes will decrease the risk of chronic depredation in the Area of Depredating Wolves.

(8) Qualifying Contingencies and Counting Incidents:

(a) An incident of depredation is a single event resulting in the injury or death of one or more lawfully present livestock that is reported to ODFW for investigation, and upon investigation by ODFW or its agent(s), ODFW confirms to have been caused by a wolf or group of wolves.

(b) A qualifying incident of depredation is a confirmed incident of depredation for the purposes of this rule if:

(A) The depredation is outside of an Area of Known Wolf Activity or Area of Depredating Wolves. Only the first confirmed depredation by a wolf or wolves may count as a qualifying depredation,

(B) In an Area of Known Wolf Activity, the landowner or lawful occupant of the land where the depredation occurred had:

(i) At least seven days prior to the incident of depredation, removed, treated or disposed of all intentionally placed or known and reasonably accessible unnatural attractants of potential wolf-livestock conflict, such as bone or carcass piles or disposal sites, and

(ii) Prior to and on the day of the incident of depredation, been using at least one measure ODFW deems most appropriate from non-lethal deterrence measures identified pursuant to section (7)(b)(D) to protect calving operations, nursing cattle, sheep operations, or other reasonably protectable situations, not including open range situations. Once a confirmed depredation has occurred in an Area of Known Wolf Activity and while ODFW is in the process of designating an Area of Depredating Wolves and creating an area-specific conflict deterrence plan, only one additional confirmed depredation in an area may count as a qualifying depredation under this subsection.

(C) In an Area of Depredating Wolves, the landowner or lawful occupant of the land where the depredation occurred had:

(i) Complied with subsection (B) of this section, and

(ii) Prior to and on the day of the incident of depredation was implementing at least one non-lethal measure identified in the area-specific conflict deterrence plan developed under subsection (7)(d)(B) that is specific to the location, type of livestock operation, time of the year, and/or period of livestock production associated with the depredation. The conflict deterrence plan measure implemented by a landowner or lawful occupant must address wolf-livestock conflict in open range situations when that situation exists.

(c) Human presence, when used as a non-lethal measure under this rule, is presence which could reasonably be expected to deter wolf-livestock conflict under the circumstances and, regardless of the temporal requirements of sections (7)(b)(B) and (C) of this rule, may be considered an appropriate non-lethal measure if it:

(A) Occurs at a proximate time prior to and in an area proximate to a confirmed depredation as determined by ODFW, and

(B) Indicates a timely response to wolf location information in situations of potential wolf-livestock conflict.

(9) Transparency and Public Disclosure.

(a) Except as provided in section (c) below, prior to using lethal force to address chronic wolf depredation, and in a timely fashion, ODFW shall document and make publicly available on at least its website:

(A)The determinations and supporting findings referenced in section (7)(f) of this rule;

(B) Information including but not limited to summaries of confirmed incidents of depredation and associated depredation investigation reports, maps of areas of known wolf activity and areas of depredating wolves, including changes and amendments to those maps, and area specific conflict deterrence plans; and

(C) Documentation of measures implemented pursuant to Section 8 of this rule. In documenting the removal of unnatural attractants and implementation of conflict deterrence measures, the Department may rely upon documented personal observation and/or written statements by the owner or lawful occupant of the land where qualifying incidents of depredation have occurred that confirm the non-lethal deterrence measures being utilized prior to and at the time of the qualifying depredation.

(b) In any signed statements and other information publicly disclosed pursuant to this section, the Department shall redact from public disclosure the personal information of landowners, lawful occupants, or other relevant individuals consistent with the Oregon public records law, ORS Chapter 192.

(c) In the case where the conditions in section (7)(f) of this rule have been met but strict compliance with the public disclosure requirements of this section cannot be accomplished without a delay that impedes ODFW's ability to pursue an immediately available opportunity to remove the wolf or wolves it reasonably believes responsible for chronic depredation prior to another depredation event on livestock, this section is deemed satisfied if, prior to the use of lethal force, ODFW:

(A) Provides email or phone notification from the ODFW Director or designee to a list of interested stakeholders communicating the findings in section (7)(f) of this rule and the Department's intent to pursue immediate lethal action based on those findings,

(B) Has previously documented and disclosed, on at least the agency's website, the information referenced in subsections (a)(A)-(C) of this section with respect to all but the most recent qualifying depredation that resulted in ODFW's determination to pursue lethal action, and

(C) Provides the remaining information referenced in subsections (a)(A)–(C) of this rule in a timely manner with respect to the most recent qualifying incident that ODFW pursues with immediate lethal action.

(10) Duration of chronic depredation lethal take authority. Take authority issued pursuant to subsection (7) expires:

(a) When the wolf or wolves identified for lethal removal have been removed by ODFW or any other party.

(b) ODFW may reinstate its take authority if ODFW confirms one additional qualifying incident of depredation within two months after the last confirmed qualifying depredation by what it believes to be a member or members of the same wolf pack and non-lethal efforts specified in Section 8 have continued to be implemented by the owner or lawful occupant of land where the additional depredation occurs;

(c) 45 days after issuance of the take authority and determination referenced in section (7)(f), unless ODFW confirms, within that time period, another qualifying incident of depredation on livestock by what it believes to be the same wolf or wolves identified for lethal removal and non-lethal efforts specified in Section 8 have continued to be implemented by the owner or lawful occupant of land where the additional depredation occurs; or

(d) If ODFW determines the wolf or wolves identified for lethal removal have left the Area of Depredating Wolves. To support this determination, data must show more than just a short-term or seasonal movement outside the area's boundary.

(e) Except as allowed under subsections (b) and (c) of this Section, any subsequent authorization or reinstatement of take authority by the Department must comply with Sections 7 through 9 of this rule, and must be based upon at least one additional qualifying depredation.

(11) Lethal take in the case of extreme circumstances. Notwithstanding sections (7) and (8) of this rule, ODFW may authorize the use of lethal force in extreme circumstances.

(a) Extreme circumstances means:

(A) Four or more confirmed incidents of depredation of livestock by what ODFW reasonably believes to be the same wolf or wolves within seven days;

(B) ODFW determines, based on evidence it makes publicly available, that there were no intentionally placed or known and reasonably accessible unnatural attractants such as bone or carcass piles or disposal sites that contributed to the incidents of depredation, and that non-lethal measures are and will likely remain ineffective; and

(C) ODFW finds that depredation has rapidly escalated beyond the reasonable, available means of ODFW and affected livestock owners to stop additional livestock losses from occurring.

(b) A decision to utilize lethal force authority due to extreme circumstances shall be made by the ODFW director or director's designee, accompanied by the findings and determinations required in section (11)(a) made publically available on ODFW's website, and exercised within 14 days of the determination to exercise lethal force authority under this section, or of the last confirmed depredation, whichever comes later.

Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.171 - 496.192, 497.298, 497.308, 498.002, 498.006, 498.012 & 498.026
Hist.: DFW 12-2005, f. & cert. ef. 3-9-05; DFW 92-2010(Temp), f. & cert. ef. 6-29-10 thru 12-25-10; DFW 144-2010, f. & cert. ef. 10-11-10; DFW 42-2013(Temp), f. & cert. ef 5-23-13 thru 11-17-13; DFW 73-2013, f. & cert. ef. 7-12-13

635-110-0020
Harassment and Take of Wolves During Phase II (Management)

NOTE: as of October 1, 2010, these rules are pre-empted by the endangered status of the gray wolf under the federal Endangered Species Act. Once federal protections are reduced to a level below that of Oregon law, these rules will govern harassment and take of wolves in Oregon.

(1) This rule describes the types of harassment and take of wolves allowed by persons outside ODFW (or ODFW or Wildlife Services acting as their agent) during Phase II — (Management: 5–7 breeding pairs) as called for in chapter III of the Oregon Wolf Conservation and Management Plan. Other chapters of the Plan authorize ODFW to take wolves for other specified wildlife management purposes.

(2) Non-injurious harassment of wolves is allowed under the same conditions as in Phase I (OAR 635-110-0010(2)).

(3) Non-lethal injurious harassment.

(a) Non-lethal injurious harassment is allowed without a permit on private land by livestock producers or their agents on land they own or lawfully occupy. Livestock producers are encouraged to use non-injurious techniques first. There must be no identified circumstance that attracts wolf-livestock conflict, and the harassment must be reported to ODFW within 48 hours.

(b) Non-lethal injurious harassment is allowed by permit on public land by grazing permittees who are legally using public land under valid livestock grazing allotments and upon the following conditions:

(A) ODFW confirms wolf depredation on livestock or other wolf-livestock conflict in the area. "Other wolf-livestock conflict" means loitering near, testing, chasing, or otherwise disrupting livestock;

(B) ODFW considers the location of known wolf sites;

(C) There is no identified circumstance at the site which attracts wolf/livestock conflict; and

(D) The harassment is reported to ODFW within 48 hours.

(c) As to non-lethal injurious harassment on either private or public land, pursuing wolves is allowed.

(4) Relocation of wolves will be considered under the same circumstances as in Phase I (OAR 635-110-0010(4)).

(5) Lethal take of wolves in the act of attacking livestock is allowed under the same conditions as in Phase I (OAR 635-110-0010(5)).

NOTE: the Oregon Wolf Conservation and Management Plan calls for allowing lethal take of wolves in this situation without a permit on private or public land. However, the Plan recognizes that because current statute requires a permit, implementing this portion of the Plan depends upon amendment of the statute by the legislature. Should the legislature make that statutory change, the Commission will amend this rule to allow for take without permit.

(6) Lethal take to deal with chronic depredation.

(a) ODFW may authorize its personnel, authorized agents, or Wildlife Services, to use lethal force on wolves at a property owner or permittee's request if:

(A) ODFW confirms either:

(i) Two confirmed depredations by wolves on livestock in the area; or

(ii) One confirmed depredation followed by three attempted depredations (testing or stalking) in the area;

(B) The requester documents unsuccessful attempts to solve the situation through non-lethal means;

(C) No identified circumstance exists that attracts wolf-livestock conflict; and

(D) The requester has complied with applicable laws and the conditions of any harassment or take permit.

(b) Subject to the conditions specified in paragraph (c) and with a limited duration permit from ODFW, the following persons may use lethal force to deal with chronic depredation:

(A) Livestock producers (or their agents) on land they own or lawfully occupy; or

(B) Grazing permittees legally using public land.

(c) ODFW will issue a permit to use lethal force to deal with chronic depredation only if:

(A) ODFW confirms that the area has had at least two depredations by wolves on livestock;

(B) ODFW determines that wolves are routinely present on that property and present a significant risk to livestock;

(C) There is no identified circumstance at the site which attracts wolf/livestock conflict;

(D) The applicant is in compliance with applicable laws and the terms of any previous wolf permit;

(E) The applicant documents use of non-lethal methods; and

(F) Any wolf taken is considered property of the state and reported to ODFW within 48 hours.

(7) "Identified circumstance" means a condition which:

(a) ODFW determines, based upon its investigation of the situation, attracts wolves and fosters conflict between wolves and livestock; and

(b) ODFW advises the landowner, livestock producer or grazing permittee to remedy; but

(c) The landowner, livestock producer or grazing permittee fails to remedy.

(8) "In the area" means where ODFW has determined the presence of the depredating wolves.

Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.171 - 496.192, 497.298, 497.308, 498.002, 498.006, 498.012 & 498.026
Hist.: DFW 12-2005, f. & cert. ef. 3-9-05; DFW 144-2010, f. & cert. ef. 10-11-10; DFW 42-2013(Temp), f. & cert. ef 5-23-13 thru 11-17-13; DFW 73-2013, f. & cert. ef. 7-12-13

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Rule Caption: Imnaha River Sport Chinook Fisheries Close
Adm. Order No.: DFW 74-2013(Temp)
Filed with Sec. of State: 7-15-2013
Certified to be Effective: 7-19-13 thru 9-1-13
Notice Publication Date:
Rules Amended: 635-019-0090
Rules Suspended: 635-019-0090(T)
Subject: This amended rule closes the recreational spring Chinook fishery in the Imnaha River effective 11:59 p.m. Friday, July 19, 2013.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-019-0090
Inclusions and Modifications

(1) The **2013 Oregon Sport Fishing Regulations** provide requirements for the Northeast Zone. However, additional regulations may be adopted in this rule division from time to time and to the extent of any inconsistency, they supersede the **2013 Oregon Sport Fishing Regulations**.

(2) The Umatilla River, from the Highway 730 bridge upstream to the Reservation boundary located upstream from the Highway 11 bridge at Pendleton is closed to spring Chinook angling effective 12:01 a.m. Thursday, May 16, 2013. All other sport fishing regulations as stated on page 74 of the **2013 Oregon Sport Fishing Regulations** remain in effect.

(3) Special regulations for Wallowa Lake have been modified to allow for a daily bag limit of twenty (20) kokanee per day, no minimum length and no more than five (5) over 12 inches in length. All other General, Statewide and Northeast Zone Regulations, as provided in the **2013 Oregon Sport Fishing Regulations**, remain in effect.

(4) Lookingglass Creek from the Moses Creek Lane Bridge (County Road 42) to the confluence of Jarboe Creek is open to angling for adipose fin-clipped jack Chinook salmon from June 1 through June 21, 2013.

(a) The daily bag limit is five (5) adipose fin-clipped jacks; two daily limits in possession. All adult Chinook must be released unharmed.

(b) During the duration of the spring Chinook angling season as described in section (4) above, the area closure listed for Lookinglass Creek in the **2013 Oregon Sport Fishing Regulations**, Northeast Zone Special Regulations is modified to read: Lookingglass Creek closed between Jarboe Creek and 200 feet upstream of the hatchery water intake.

(c) Hook gap restrictions listed in the Northeast Zone Special Regulations for Lookingglass Creek are removed for the duration of the spring Chinook angling season described in section (4) above.

(d) All other General, Statewide and Northeast Zone Regulations, as provided in the **2013 Oregon Sport Fishing Regulations**, remain in effect.

(5) The Imnaha River from the mouth to Summit Creek Bridge (River Mile 45) is open to angling for adipose fin-clipped adult Chinook salmon from July 5 through July 19, 2013.

(a) From July 5 through July 7, the daily bag limit is two (2) adipose fin-clipped adult Chinook and five (5) adipose fin-clipped jacks; two daily jack salmon limits in possession. It is illegal to continue fishing for jack Chinook once the adult bag limit has been met.

(b) From July 7 through July 19, the daily bag limit is five (5) adipose fin-clipped jacks; two daily jack salmon limits in possession; and adult Chinook salmon may not be retained.

(c) All other General, Statewide and Northeast Zone Regulations, as provided in the **2013 Oregon Sport Fishing Regulations**, remain in effect.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 496.138, 496.146 & 506.119

Stats. Implemented: 496.162 & 506.129

Hist.: FWC 82-1993, f. 12-22-93, cert. ef. 1-1-94; FWC 57-1994(Temp), f. 8-30-94, cert. ef. 10-1-94; FWC 22-1995, f. 3-7-95, cert. ef. 3-10-95; FWC 70-1995, f. 8-29-95, cert. ef. 9-1-95; FWC 77-1995, f. 9-13-95, cert. ef. 1-1-96; FWC 27-1996(Temp), f. 5-24-96, cert. ef. 5-25-96; FWC 57-1996(Temp), f. 9-27-96, cert. ef. 10-1-96; FWC 72-1996, f. 12-31-96, cert. ef. 1-1-97; FWC 26-1997(Temp), f. 4-23-97, cert. ef. 5-17-97; FWC 75-1997, f. 12-31-97, cert. ef. 1-1-98; DFW 13-1998(Temp), f. & cert. ef. 2-26-98 thru 4-15-98; DFW 100-1998, f. 12-23-98, cert. ef. 1-1-99; DFW 5-1999(Temp), f. 2-5-99, cert. ef. 2-6-99 thru 2-19-99; DFW 8-1999(Temp), f. & cert. ef. 2-23-99 thru 4-15-99; DFW 37-1999(Temp), f. 5-24-99, cert. ef. 5-29-99 thru 6-5-99; DFW 43-1999(Temp), f. & cert. ef. 6-10-99 thru 6-13-99; DFW 45-1999(Temp), f. & cert. ef. 6-14-99 thru 6-20-99; DFW 96-1999, f. 12-27-99, cert. ef. 1-1-00; DFW 17-2000(Temp), f. 4-10-00, cert. ef. 4-16-00 thru 6-30-00; DFW 64-2000(Temp), f. 9-21-00, cert. ef. 9-22-00 thru 3-20-01; DFW 83-2000(Temp), f. 12-28-00, cert. ef. 1-1-01 thru 1-31-01; DFW 1-2001, f. 1-25-01, cert. ef. 2-1-01; DFW 5-2001(Temp), f. 2-22-01, cert. ef. 2-24-01 thru 4-15-01; DFW 39-2001(Temp) f. 5-23-01, cert. ef. 5-26-01 thru 7-1-01; DFW 40-2001(Temp) f. & cert. ef. 5-24-01 thru 11-20-01; DFW 45-2001(Temp), f. 6-1-01, cert. ef. 6-2-01 thru 7-31-01; DFW 49-2001(Temp), f. 6-19-01, cert. ef. 6-22-01 thru 7-31-01; DFW 70-2001, f. & cert. ef. 8-10-01; DFW 71-2001(Temp), f. 8-10-01, cert. ef. 9-1-01 thru 12-31-01; DFW 96-2001(Temp), f. 10-4-01, cert. ef. 12-1-01 thru 12-31-01; DFW 122-2001(Temp), f. & cert. ef. 12-31-01 thru 5-31-02; DFW 123-2001, f. 12-31-01, cert. ef. 1-1-02; DFW 26-2002, f. & cert. ef. 3-21-02; DFW 52-2002(Temp), f. 5-22-02, cert. ef. 5-26-02 thru 7-1-02; DFW 53-2002(Temp), f. 5-24-02, cert. ef. 5-26-02 thru 7-1-02; DFW 57-2002(Temp), f. & cert. ef. 5-30-02 thru 7-1-02; DFW 91-2002(Temp) f. 8-19-02, cert. ef 8-20-02 thru 11-1-02 (Suspended by DFW 101-2002(Temp), f. & cert. ef. 10-3-02 thru 11-1-02); DFW 130-2002, f. 11-21-02, cert. ef. 1-1-03; DFW 44-2003(Temp), f. 5-23-03, cert. ef. 5-28-03 thru 7-1-03; DFW 48-2003(Temp), f. & cert. ef. 6-5-03 thru 7-1-03; DFW 125-2003, f. 12-11-03, cert. ef. 1-1-04; DFW 40-2004(Temp), f. 5-7-04, cert. ef. 5-13-04 thru 7-1-04; DFW 46-2004(Temp), f. 5-21-04, cert. ef. 5-22-04 thru 7-1-04; DFW 55-2004(Temp), f. 6-16-04, cert. ef. 6-19-04 thru 7-5-04; DFW 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 42-2005(Temp), f. & cert. ef. 5-13-05 thru 9-1-05; DFW 61-2005(Temp), f. 6-22-05, cert. ef. 6-25-05 thru 7-4-05; Administrative correction 7-20-05; DFW 99-2005(Temp), f. 8-24-05, cert. ef. 8-26-05 thru 9-30-05; Administrative correction 10-19-05; DFW 136-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 28-2006(Temp), f. & cert. ef. 5-15-06 thru 6-30-06; DFW 33-2006(Temp), f. 5-24-06, cert. ef. 5-25-06 thru 6-30-06; Administrative correction 7-21-06; DFW 79-2006, f. 8-11-06, cert. ef. 1-1-07; DFW 12-2007(Temp), f. 2-28-07, cert. ef. 3-1-07 thru 8-27-07; DFW 30-2007(Temp), f. 5-9-07, cert. ef. 5-10-07 thru 9-30-07; DFW 34-2007(Temp), f. 5-25-07, cert. ef. 5-26-07 thru 9-30-07; Administrative correction 10-16-07; DFW 136-2007, f. 12-31-07, cert. ef. 1-1-08; DFW 56-2008(Temp), f. 5-30-08, cert. ef. 5-31-08 thru 6-30-08; DFW 76-2008(Temp), f. & cert. ef. 7-9-08 thru 9-1-08; DFW 156-2008, f. 12-31-08, cert. ef. 1-1-09; DFW 128-2009(Temp), f. 10-12-09, cert. ef. 10-18-09 thru 4-15-10; DFW 131-2009(Temp), f. 10-14-09, cert. ef. 10-18-09 thru 4-15-10; DFW 144-2009, f. 12-8-09, cert. ef. 1-1-10; DFW 54-2010(Temp), f. 5-6-10, cert. ef. 5-22-10 thru 9-1-10; DFW 95-2010(Temp), f. 7-1-10, cert. ef. 7-11-10 thru 9-1-10; DFW 102-2010(Temp), f. 7-20-10, cert. ef 7-25-10 thru 9-1-10; Administrative correction 9-22-10; DFW 171-2010, f. 12-30-10, cert. ef. 1-1-11; DFW 49-2011(Temp), f. 5-16-11, cert. ef. 5-28-11 thru 9-1-11; DFW 64-2011(Temp), f. 6-10-11, cert. ef. 6-13-11 thru 9-1-11; DFW 90-2011(Temp), f. & cert. ef. 7-11-11 thru 9-1-11; DFW 92-2011(Temp), f. 7-12-11, cert. ef. 7-16-11 thru 10-31-11; DFW 99-2011(Temp), f. 7-21-11, cert. ef. 7-23-11 thru 9-1-11; DFW 104-2011(Temp), f. 8-1-11, cert. ef. 8-7-11 thru 9-1-11; Administrative correction 9-23-11; DFW 163-2011, f. 12-27-11, cert. ef. 1-1-12; DFW 48-2012(Temp), f. 5-18-12, cert. ef. 5-23-12 thru 9-1-12; DFW 50-2012(Temp), f. 5-22-12, cert. ef. 5-24-12 thru 9-1-12; DFW 61-2012(Temp), f. & cert. ef. 6-11-12 thru 8-31-12; DFW 69-2012(Temp), f. 6-20-12, cert. ef. 6-22-12 thru 9-1-12; DFW 70-2012(Temp), f. 6-26-12, cert. ef. 6-27-12 thru 9-1-12; DFW 72-2012(Temp), f. 6-29-12, cert. ef. 7-1-12 thru 8-31-12; DFW 86-2012(Temp), f. 7-10-12, cert. ef. 7-15-12 thru 9-1-12; Administrative correction 9-20-12; DFW 149-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 153-2012(Temp), f. 12-28-12, cert. ef. 1-1-13 thru 4-30-13; DFW 31-2013(Temp), f. 5-14-13, cert. ef. 5-16-13 thru 6-30-13; DFW 39-2013(Temp), f. 5-22-13, cert. ef. 5-24-13 thru 11-19-13; DFW 46-2013(Temp), f. 5-30-13, cert. ef. 6-1-13 thru 11-26-13; DFW 62-2013(Temp), f. 6-26-13, cert. ef. 7-5-13 thru 12-31-13; DFW 74-2013(Temp), f. 7-15-13, cert. ef. 7-19-13 thru 9-1-13

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Rule Caption: Lower Deschutes River Sport Fall Chinook Fishery Opens August 1st
Adm. Order No.: DFW 75-2013(Temp)
Filed with Sec. of State: 7-15-2013
Certified to be Effective: 8-1-13 thru 10-31-13
Notice Publication Date:
Rules Amended: 635-018-0090
Subject: The amended rule allows the sport harvest of fall Chinook salmon in the Lower Deschutes River from August 1 through October 31, 2013 from the mouth at the I-84 Bridge upstream to Sherars Falls. Catch limits for this fishery is any two adults and five jacks per day.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-018-0090
Inclusions and Modifications

(1) The **2013 Oregon Sport Fishing Regulations** provide requirements for the Central Zone. However, additional regulations may be adopted in this rule division from time to time and to the extent of any inconsistency, they supersede the **2013 Oregon Sport Fishing Regulations**.

(2) The Deschutes River from the mouth at the I-84 Bridge upstream to Sherars Falls is open to angling for trout, steelhead and Chinook salmon from August 1 through October 31, 2013.

(a) The catch limit for Chinook, during the period described in section (2) above, is any two adults and five jacks per day.

(b) Catch limits and restrictions applying to trout, steelhead, and coho salmon remain unchanged from those listed in the 2013 Oregon Sport Fishing Regulations for Area 1 of the Deschutes River.

Stat. Auth.: ORS 496.138, 496.146, 497.121 & 506.119

Stats. Implemented: ORS 496.004, 496.009, 496.162 & 506.129

Hist.: FWC 82-1993, f. 12-22-93, cert. ef. 1-1-94; FWC 20-1994(Temp), f. & cert. ef. 4-11-94; FWC 24-1994(Temp), f. 4-29-94, cert. ef. 4-30-94; FWC 34-1994(Temp), f. 6-14-94, cert. ef. 6-16-94; FWC 54-1994, f. 8-25-94, cert. ef. 9-1-94; FWC 65-1994(Temp), f. 9-15-94, cert. ef. 9-17-94; FWC 67-1994(Temp), f. & cert. ef. 9-26-94; FWC 70-1994, f. 10-4-95, cert. ef. 11-1-94; FWC 18-1995, f. 3-2-95, cert. ef. 4-1-95; FWC 60-1995(Temp), f. 7-24-95, cert. ef. 8-1-95; FWC 77-1995, f. 9-13-95, cert. ef. 1-1-96; FWC 11-1996(Temp), f. 3-8-96, cert. ef. 4-1-96; FWC 32-1996(Temp), f. 6-7-96, cert. ef. 6-16-96, FWC 38-1996(Temp), f. 6-14-96, cert. ef. 7-1-96; FWC 72-1996, f. 12-31-96, cert. ef. 1-1-97; FWC 20-1997, f. & cert. ef. 3-24-97; FWC 21-1997, f. & cert. ef. 4-1-97; FWC 27-1997(Temp) f. 5-2-97, cert. ef. 5-9-97; FWC 75-1997, f. 12-31-97, cert. ef. 1-1-98; DFW 25-1998(Temp), f. & cert. ef. 3-25-98 thru 8-31-98; DFW 56-1998(Temp), f. 7-24-98, cert. ef. 8-1-98 thru 10-31-98; DFW 70-1998, f. & cert. ef. 8-28-98; DFW 100-1998, f. 12-23-98, cert. ef. 1-1-99; DFW 31-1999, f. & cert. ef. 5-3-99; DFW 78-1999, f. & cert. ef. 10-4-99; DFW 96-1999, f. 12-27-99, cert. ef. 1-1-00; DFW 12-2000(Temp), f. 3-20-00, cert. ef. 4-15-00 thru 7-31-00; DFW 27-2000(Temp), f. 5-15-00, cert. ef. 8-1-00 thru 10-31-00; DFW 28-2000, f. 5-23-00, cert. ef. 5-24-00 thru 7-31-00; DFW 83-2000(Temp), f. 12-28-00, cert. ef. 1-1-01 thru 1-31-01; DFW 1-2001, f. 1-25-01, cert. ef. 2-1-01; DFW 13-2001(Temp), f. 3-12-01, cert. ef. 4-7-01 thru 7-31-01; DFW 40-2001(Temp) f. & cert. ef. 5-24-01 thru 11-20-01; DFW 44-2001(Temp), f. 5-25-01, cert. ef. 6-1-01 thru 7-31-01; DFW 123-2001, f. 12-31-01, cert. ef. 1-1-02; DFW 5-2002(Temp) f. 1-11-02 cert. ef. 1-12-02 thru 7-11-02; DFW 23-2002(Temp), f. 3-21-02, cert. ef. 4-6-02 thru 7-31-02; DFW 25-2002(Temp), f. 3-22-02, cert. ef. 4-6-02 thru 7-31-02; DFW 26-2002, f. & cert. ef. 3-21-02; DFW 62-2002, f. 6-14-02, cert. ef. 7-11-02; DFW 74-2002(Temp), f. 7-18-02, cert. ef. 8-1-02 thru 10-31-02; DFW 91-2002(Temp) f. 8-19-02, cert. ef 8-20-02 thru 11-1-02 (Suspended by DFW 101-2002(Temp), f. & cert. ef. 10-3-02 thru 11-1-02); DFW 97-2002(Temp), f. & cert. ef. 8-29-02 thru 10-31-02; DFW 130-2002, f. 11-21-02, cert. ef. 1-1-03; DFW 26-2003(Temp), f. 3-28-03, cert. ef. 4-15-03 thru 7-31-03; DFW 66-2003(Temp), f. 7-17-03, cert. ef. 8-1-03 thru 10-31-03; DFW 125-2003, f. 12-11-03, cert. ef. 1-1-04; DFW 23-2004(Temp), f. 3-22-04, cert. ef. 4-1-04 thru 7-31-04; DFW 77-2004(Temp), f. 7-28-04, cert. ef. 8-1-04 thru 10-31-04, Administrative correction 11-22-04; DFW 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 19-2005(Temp), f. 3-16-05, cert. ef. 4-15-05 thru 7-31-05; DFW 41-2005(Temp), f. 5-13-05, cert. ef. 5-15-05 thru 7-31-05; DFW 83-2005(Temp), f. 7-29-05, cert. ef. 8-1-05 thru 10-31-05; DFW 84-2005(Temp), f. & cert. ef. 8-1-05 thru 12-31-05; DFW 136-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 59-2006(Temp), f. 7-10-06, cert. ef. 8-1-06 thru 10-31-06; DFW 79-2006, f. 8-11-06, cert. ef. 1-1-07; DFW 18-2007(Temp), f. 3-22-07, cert. ef. 4-15-07 thru 7-31-07; DFW 55-2007(Temp), f. 7-6-07, cert. ef. 8-1-07 thru 10-31-07; Administrative correction 11-17-07; DFW 136-2007, f. 12-31-07, cert. ef. 1-1-08; DFW 26-2008(Temp), f. 3-17-08, cert. ef. 4-15-08 thru 7-31-08; DFW 27-2008(Temp), f. 3-24-08, cert. ef. 5-1-08 thru 10-27-08; Administrative correction 11-18-08; DFW 156-2008, f. 12-31-08, cert. ef. 1-1-09; DFW 16-2009(Temp), f. 2-25-09, cert. ef. 4-15-09 thru 6-30-09; DFW 61-2009(Temp), f. 6-1-09, cert. ef. 8-1-09 thru 10-31-09; DFW 104-2009(Temp), f. 8-28-09, cert. ef. 9-1-09 thru 12-31-09; DFW 144-2009, f. 12-8-09, cert. ef. 1-1-10; DFW 7-2010(Temp), f. 1-25-10, cert. ef. 4-1-10 thru 7-31-10; DFW 27-2010(Temp), f. 3-8-10, cert. ef. 4-15-10 thru 7-31-10; DFW 66-2010(Temp), f. 5-18-10, cert. ef. 5-22-10 thru 10-31-10; DFW 86-2010(Temp), f. 6-23-10, cert. ef. 7-1-10 thru 10-31-10; DFW 106-2010(Temp), f. 7-26-10, cert. ef. 8-1-10 thru 12-31-10; DFW 164-2010(Temp), f. 12-28-10, cert. ef. 1-1-11 thru 6-29-11; DFW 171-2010, f. 12-30-10, cert. ef. 1-1-11; DFW 16-2011(Temp), f. 2-16-11, cert. ef. 4-15-11 thru 7-31-11; DFW 17-2011(Temp), f. 2-17-11, cert. ef. 4-15-11 thru 7-31-11; DFW 42-2011(Temp), f. & cert. ef. 5-10-11 thru 10-31-11; DFW 93-2011(Temp), f. 7-13-11, cert. ef. 8-1-11 thru 10-31-11; DFW 123-2011(Temp), f. 9-2-11, cert. ef. 9-3-11 thru 12-31-11; DFW 160-2011(Temp), f. 12-20-11, cert. ef. 1-1-12 thru 4-30-12; DFW 163-2011, f. 12-27-11, cert. ef. 1-1-12; DFW 21-2012, f. & cert. ef. 3-12-12; DFW 34-2012(Temp), f. 4-13-12, cert. ef. 4-15-12 thru 7-31-12; DFW 55-2012(Temp), f. & cert. 6-4-12 thru 6-30-12; Administrative correction, 8-1-12; DFW 88-2012(Temp), f. 7-16-12, cert. ef. 8-1-12 thru 10-31-12; Administrative correction 11-23-12; DFW 149-2012, f. 12-27-12, cert. ef. 1-1-13; DFW 16-2013(Temp), f. 2-25-13, cert. ef. 4-15-13 thru 6-30-13; DFW 75-2013(Temp), f. 7-15-13, cert. ef. 8-1-13 thru 10-31-13

Department of Forestry
Chapter 629

Rule Caption: Amends requirements for written plans near streams and wetlands; process includes FPA housekeeping updates.
Adm. Order No.: DOF 2-2013
Filed with Sec. of State: 7-11-2013
Certified to be Effective: 9-1-13
Notice Publication Date: 4-1-2013
Rules Adopted: 629-600-0050, 629-650-0005
Rules Amended: 629-600-0100, 629-605-0150, 629-605-0160, 629-605-0170, 629-605-0173, 629-605-0180, 629-610-0000, 629-610-0020, 629-610-0070, 629-610-0090, 629-615-0100, 629-615-0300, 629-620-0000, 629-623-0100, 629-623-0200, 629-623-0400, 629-625-0000, 629-625-0500, 629-625-0600, 629-625-0650, 629-630-0800, 629-635-0100, 629-635-0200, 629-640-0000, 629-640-0100, 629-640-0105, 629-640-0200, 629-645-0000, 629-645-0030, 629-645-0040, 629-645-0050, 629-650-0000, 629-660-0050, 629-665-0230, 629-670-0214, 629-680-0020
Rules Repealed: 629-635-0130
Subject: The Oregon Department of Forestry has initiated permanent rulemaking for the above administrative rules adopted under the Forest Practices Act (FPA). The primary rule change within this rulemaking process is reflected in Oregon Administrative Rule (OAR) 629-605-0170 Written Plans. These proposed rule amendments also include associated supporting edits within the adopted administrative rules. In 1988 a 100 foot distance was set to define an area in which a statutory written plan was required near certain protected resources, not the area to be protected (Oregon Revised Statute (ORS) 527.670(4)). In 2011 House Bill (HB) 2165 passed allowing the State Forester, acting under the authority of the Oregon Board of Forestry (BOF), to waive the requirement for statutory written plans if the operation activity will not directly affect riparian management areas (RMA) of a fish or domestic use stream, or a significant wetland that is not classified as an estuary (ORS 527.670). These resource types have varying RMAs of 100 feet or less. Entry to the RMA requires compliance with Division 635 the Water Protection Rules adopted by the FPA. The implementation of HB 2165 will promote efficiency within the Department and allow Stewardship Foresters to focus on statutory written plans for operations that will be applying specific rules to work within the RMA.

This rulemaking process included general FPA housekeeping edits to a number of rules. The general FPA housekeeping changes correct grammatical errors, update outdated references and establish a title for the forest practice rules. They do not change the intent or effect of the rules adopted under the FPA. All of these updates and proposed rule changes have been reviewed by the Regional Forest Practices Committees and the Committee for Family Forestland which are advisory committees to the Board of Forestry.

On June 5th, 2013 the Board of Forestry adopted all administrative rules, revisions and the repeal listed in this notice.
Rules Coordinator: Sabrina Perez—(503) 945-7210

629-600-0050
Forest Practice Rules

OAR chapter 629, divisions 600 through 680 are known as the forest practice rules.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.710 & 527.715
Hist.: DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-600-0100
Definitions

As used in OAR chapter 629, divisions 605 through 669 and divisions 680 through 699, unless otherwise required by context:

(1) "Abandoned resource site" means a resource site that the State Forester determines is not active.

(2) "Active resource site" means a resource site that the State Forester determines has been used in the recent past by a listed species. 'Recent past' shall be identified for each species in administrative rule. Resource sites that are lost or rendered not viable by natural causes are not considered active.

(3) "Active roads" are roads currently being used or maintained for the purpose of removing commercial forest products.

(4) "Aquatic area" means the wetted area of streams, lakes and wetlands up to the high water level. Oxbows and side channels are included if they are part of the flow channel or contain fresh water ponds.

(5) "Artificial reforestation" means restocking a site by planting trees or through the manual or mechanical distribution of seeds.

(6) "Basal area" means the area of the cross-section of a tree stem derived from DBH.

(7) "Basal area credit" means the credit given towards meeting the live tree requirements within riparian management areas for placing material such as logs, rocks or rootwads in a stream, or conducting other enhancement activities such as side channel creation or grazing exclosures.

(8) "Bog" means a wetland that is characterized by the formation of peat soils and that supports specialized plant communities. A bog is a hydrologically closed system without flowing water. It is usually saturated, relatively acidic, and dominated by ground mosses, especially sphagnum. A bog may be forested or non-forested and is distinguished from a swamp and a marsh by the dominance of mosses and the presence of extensive peat deposits.

(9) "Channel" is a distinct bed or banks scoured by water which serves to confine water and that periodically or continually contains flowing water.

(10) "Chemicals" means and includes all classes of pesticides, such as herbicides, insecticides, rodenticides, fungicides, plant defoliants, plant desiccants, and plant regulators, as defined in ORS 634.006(8); fertilizers, as defined in 633.311; petroleum products used as carriers; and chemical application adjuvants, such as surfactants, drift control additives, anti-foam agents, wetting agents, and spreading agents.

(11) "Commercial" means of or pertaining to the exchange or buying and selling of commodities or services. This includes any activity undertaken with the intent of generating income or profit; any activity in which a landowner, operator or timber owner receives payment from a purchaser of forest products; any activity in which an operator or timber owner receives payment or barter from a landowner for services that require notification under OAR 629-605-0140; or any activity in which the landowner, operator, or timber owner barters or exchanges forest products for goods or services. This does not include firewood cutting or timber milling for personal use.

(12) "Completion of the operation" means harvest activities have been completed to the extent that the operation area will not be further disturbed by those activities.

(13) "Conflict" means resource site abandonment or reduced resource site productivity that the State Forester determines is a result of forest practices.

(14) "Debris torrent-prone streams" are designated by the State Forester to include channels and confining slopes that drain watersheds containing high landslide hazard locations that are of sufficient confinement and channel gradient to allow shallow, rapid landslide movement.

(15) "Department" means the Oregon Department of Forestry.

(16) "Diameter breast height" (DBH) means the diameter of a tree inclusive of the bark measured four and one-half feet above the ground on the uphill side of the tree.

(17) "Domestic water use" means the use of water for human consumption and other household human use.

(18) "Dying or recently dead tree" means a tree with less than ten percent live crown or a standing tree which is dead, but has a sound root system and has not lost its small limbs. Needles or leaves may still be attached to the tree.

(19) "Estuary" means a body of water semi-enclosed by land and connected with the open ocean within which saltwater is usually diluted by freshwater derived from the land. "Estuary" includes all estuarine waters, tidelands, tidal marshes, and submerged lands extending upstream to the head of tidewater. However, the Columbia River Estuary extends to the western edge of Puget Island.

(20) "Exposure categories" are used to designate the likelihood of persons being present in structures or on public roads during periods when shallow, rapidly moving landslides may occur.

(21) "Filling" means the deposit by artificial means of any materials, organic or inorganic.

(22) "Fish use" means inhabited at any time of the year by anadromous or game fish species or fish that are listed as threatened or endangered species under the federal or state endangered species acts.

(23) "Fledging tree" means a tree or trees close to the nest which the State Forester determines are regularly used by young birds to develop flying skills.

(24) "Foraging area" means an area (usually a body of water) where bald eagles concentrate their hunting activities.

(25) "Foraging perch" means a tree or other structure that overlooks a portion of a foraging area and is habitually used by bald eagles as a vantage point while hunting.

(26) "Forestland" means land which is used for the growing and harvesting of forest tree species, regardless of how the land is zoned or taxed or how any state or local statutes, ordinances, rules or regulations are applied.

(27) "Forest practice" means any operation conducted on or pertaining to forestland, including but not limited to:

(a) Reforestation of forestland;

(b) Road construction and maintenance;

(c) Harvesting of forest tree species;

(d) Application of chemicals;

(e) Disposal of slash; and

(f) Removal of woody biomass.

(28) "Forest tree species" means any tree species capable of producing logs, fiber or other wood materials suitable for the production of lumber, sheeting, pulp, firewood or other commercial forest products except trees grown to be Christmas trees as defined in ORS 571.505 on land used solely for the production of Christmas trees.

(29) "Free to grow" means the State Forester's determination that a tree or a stand of well distributed trees, of acceptable species and good form, has a high probability of remaining or becoming vigorous, healthy, and dominant over undesired competing vegetation. For the purpose of this definition, trees are considered well distributed if 80 percent or more of the portion of the operation area subject to the reforestation requirements of the rules contains at least the minimum per acre tree stocking required by the rules for the site and not more than ten percent contains less than one-half of the minimum per acre tree stocking required by the rules for the site.

(30) "Further review area" means an area of land that may be subject to rapidly moving landslides as mapped by the State Department of Geology and Mineral Industries or as otherwise determined by the State Forester.

(31) "Geographic region" means large areas where similar combinations of climate, geomorphology, and potential natural vegetation occur, established for the purposes of implementing the water protection rules.

(32) "Harvest type 1" means an operation that requires reforestation but does not require wildlife leave trees. A harvest type 1 is an operation that leaves a combined stocking level of free to grow seedlings, saplings, poles and larger trees that is less than the stocking level established by rule of the board that represents adequate utilization of the productivity of the site.

(33) "Harvest type 2" means an operation that requires wildlife leave trees but does not require reforestation. A harvest type 2 does not require reforestation because it has an adequate combined stocking of free to grow seedlings, saplings, poles and larger trees, but leaves:

(a) On Cubic Foot Site Class I, II or III, fewer than 50 11-inch DBH trees or less than an equivalent basal area in larger trees, per acre;

(b) On Cubic Foot Site Class IV or V, fewer than 30 11-inch DBH trees or less than an equivalent basal area in larger trees, per acre; or

(c) On Cubic Foot Site Class VI, fewer than 15 11-inch DBH trees or less than an equivalent basal area in larger trees, per acre.

(34) "Harvest type 3" means an operation that requires reforestation and requires wildlife leave trees. This represents a level of stocking below which the size of operations is limited under ORS 527.740 and 527.750.

(35) "High landslide hazard location" means a specific site that is subject to initiation of a shallow, rapidly moving landslide. The following criteria shall be used to identify high landslide hazard locations:

(a) The presence, as measured on site, of any slope in western Oregon (excluding competent rock outcrops) steeper than 80 percent, except in the Tyee Core Area, where it is any slope steeper than 75 percent; or

(b) The presence, as measured on site, of any headwall or draw in western Oregon steeper than 70 percent, except in the Tyee Core Area, where it is any headwall or draw steeper than 65 percent.

(c) Notwithstanding the slopes specified in (a) or (b) above, field identification of atypical conditions by a geotechnical specialist may be used to develop site specific slope steepness thresholds for any part of the state where the hazard is equivalent to (a) or (b) above. The final determination of equivalent hazard shall be made by the State Forester.

(36) "High water level" means the stage reached during the average annual high flow. The "high water level" often corresponds with the edge of streamside terraces, a change in vegetation, or a change in soil or litter characteristics.

(37) "Hydrologic function" means soil, stream, wetland and riparian area properties related to the storage, timing, distribution, and circulation of water.

(38) "Important springs" are springs in arid parts of eastern Oregon that have established wetland vegetation, flow year round in most years, are used by a concentration of diverse animal species, and by reason of sparse occurrence have a major influence on the distribution and abundance of upland species.

(39) "Inactive roads" are roads used for forest management purposes exclusive of removing commercial forest products.

(40) "Key components" means the attributes which are essential to maintain the use and productivity of a resource site over time. The key components vary by species and resource site. Examples include fledging trees or perching trees.

(41) "Lake" means a body of year-round standing open water.

(a) For the purposes of the forest practice rules, lakes include:

(A) The water itself, including any vegetation, aquatic life, or habitats therein; and

(B) Beds, banks or wetlands below the high water level which may contain water, whether or not water is actually present.

(b) "Lakes" do not include water developments as defined in section (90) of this rule.

(42) "Landslide mitigation" means actions taken to reduce potential landslide velocity or re-direct shallow, rapidly moving landslides near structures and roads so risk to persons is reduced.

(43) "Landowner" means any individual, combination of individuals, partnership, corporation or association of whatever nature that holds an ownership interest in forestland, including the state and any political subdivision thereof.

(44) "Large lake" means a lake greater than eight acres in size.

(45) "Large wood key piece" means a portion of a bole of a tree, with or without the rootwad attached, that is wholly or partially within the stream, that meets the length and diameter standards appropriate to stream size and high water volumes established in the "Guide to Placement of Wood, Boulders and Gravel for Habitat Restoration," developed by the Oregon Department of Forestry, Oregon Department of Fish and Wildlife, Oregon Department of State Lands, and Oregon Watershed Enhancement Board, January 2010.

(46) "Live tree" means a tree that has 10 percent or greater live crown.

(47) "Local population" means the number of birds that live within a geographical area that is identified by the State Forester. For example: the area may be defined by physical boundaries, such as a drainage or subbasin.

(48) "Main channel" means a channel that has flowing water when average flows occur.

(49) "Natural barrier to fish use" is a natural feature such as a waterfall, increase in stream gradient, channel constriction, or other natural channel blockage that prevents upstream fish passage.

(50) "Natural reforestation" means restocking a site with self-grown trees resulting from self-seeding or vegetative means.

(51) "Nest tree" means the tree, snag, or other structure that contains a bird nest.

(52) "Nesting territory" means an area identified by the State Forester that contains, or historically contained, one or more nests of a mated pair of birds.

(53) "Operation" means any commercial activity relating to the establishment, management or harvest of forest tree species except as provided by the following:

(a) The establishment, management or harvest of Christmas trees, as defined in ORS 571.505, on land used solely for the production of Christmas trees.

(b) The establishment, management or harvest of hardwood timber, including but not limited to hybrid cottonwood that is:

(A) Grown on land that has been prepared by intensive cultivation methods and that is cleared of competing vegetation for at least three years after tree planting;

(B) Of a species marketable as fiber for inclusion in the furnish for manufacturing paper products;

(C) Harvested on a rotation cycle that is 12 or fewer years after planting; and

(D) Subject to intensive agricultural practices such as fertilization, cultivation, irrigation, insect control and disease control.

(c) The establishment, management or harvest of trees actively farmed or cultured for the production of agricultural tree crops, including nuts, fruits, seeds and nursery stock.

(d) The establishment, management or harvest of ornamental, street or park trees within an urbanized area, as that term is defined in ORS 221.010.

(e) The management or harvest of juniper species conducted in a unit of less than 120 contiguous acres within a single ownership.

(f) The establishment or management of trees intended to mitigate the effects of agricultural practices on the environment or fish and wildlife resources, such as trees that are established or managed for windbreaks, riparian filters or shade strips immediately adjacent to actively farmed lands.

(g) The development of an approved land use change after timber harvest activities have been completed and land use conversion activities have commenced.

(54) "Operator" means any person, including a landowner or timber owner, who conducts an operation.

(55) "Other wetland" means a wetland that is not a significant wetland or stream-associated wetland.

(56) "Perch tree" means a tree identified by the State Forester which is used by a bird for resting, marking its territory, or as an approach to its nest.

(57) "Plan for an Alternate Practice" means a document prepared by the landowner, operator or timber owner, submitted to the State Forester for written approval describing practices different than those prescribed in statute or administrative rule.

(58) "Relief culvert" means a structure to relieve surface runoff from roadside ditches to prevent excessive buildup in volume and velocity.

(59) "Removal" means the taking or movement of any amount of rock, gravel, sand, silt, or other inorganic substances.

(60) "Replacement tree" means a tree or snag within the nesting territory of a bird that is identified by the State Forester as being suitable to replace the nest tree or perch tree when these trees become unusable.

(61) "Resource site" is defined for the purposes of protection and for the purposes of requesting a hearing.

(a) For the purposes of protection:

(A) For threatened and endangered bird species, "resource site" is the nest tree, roost trees, or foraging perch and all identified key components.

(B) For sensitive bird nesting, roosting and watering sites, "resource site" is the nest tree, roost tree or mineral watering place, and all identified key components.

(C) For significant wetlands "resource site" is the wetland and the riparian management area as identified by the State Forester.

(b) For the purposes of requesting a hearing under ORS 527.670(4) and 527.700(3), "resource site" is defined in OAR 629-680-0020.

(62) "Riparian area" means the ground along a water of the state where the vegetation and microclimate are influenced by year-round or seasonal water, associated high water tables, and soils which exhibit some wetness characteristics.

(63) "Riparian management area" means an area along each side of specified waters of the state within which vegetation retention and special management practices are required for the protection of water quality, hydrologic functions, and fish and wildlife habitat.

(64) "Roosting site" means a site where birds communally rest at night and which is unique for that purpose.

(65) "Roost tree" is a tree within a roosting site that is used for night time roosting.

(66) "Saplings and poles" means live trees of acceptable species, of good form and vigor, with a DBH of one to 10 inches.

(67) "Seedlings" means live trees of acceptable species of good form and vigor less than one inch in DBH.

(68) "Shallow, rapidly moving landslide" means any detached mass of soil, rock, or debris that begins as a relatively small landslide on steep slopes and grows to a sufficient size to cause damage as it moves down a slope or a stream channel at a velocity difficult for people to outrun or escape.

(69) "Side channel" means a channel other than a main channel of a stream that only has flowing water when high water level occurs.

(70) "Significant wetlands" means those wetland types listed in OAR 629-680-0310, that require site specific protection, as follows:

(a) Wetlands that are larger than eight acres;

(b) Estuaries;

(c) Bogs; and

(d) Important springs in eastern Oregon.

(71) "Snag" means a tree which is dead but still standing, and that has lost its leaves or needles and its small limbs.

(72) "Sound snag" means a snag that retains some intact bark or limb stubs.

(73) "Staging tree" is a tree within the vicinity of a roosting site that is used for perching by bald eagles before entering the roost.

(74) "State Forester" means the State Forester or the duly authorized representative of the State Forester.

(75) "Stream" means a channel, such as a river or creek, that carries flowing surface water during some portion of the year.

(a) For the purposes of the forest practice rules, streams include:

(A) The water itself, including any vegetation, aquatic life, or habitats therein;

(B) Beds and banks below the high water level which may contain water, whether or not water is actually present;

(C) The area between the high water level of connected side channels;

(D) Beaver ponds, oxbows, and side channels if they are connected by surface flow to the stream during a portion of the year; and

(E) Stream-associated wetlands.

(b) "Streams" do not include:

(A) Ephemeral overland flow (such flow does not have a channel); or

(B) Road drainage systems or water developments as defined in section (90) of this rule.

(76) "Stream-associated wetland" means a wetland that is not classified as significant and that is next to a stream.

(77) "Structural exception" means the State Forester determines that no actions are required to protect the resource site. The entire resource site may be eliminated.

(78) "Structural protection" means the State Forester determines that actions are required to protect the resource site. Examples include retaining the nest tree or perch tree.

(79) "Temporal exception" means the State Forester determines that no actions are required to prevent disturbance to birds during the critical period of use.

(80) "Temporal protection" means the State Forester determines that actions are required to prevent disturbance to birds during the critical period of use.

(81) "Timber owner" means any individual, combination of individuals, partnership, corporation or association of whatever nature, other than a landowner, that holds an ownership interest in any forest tree species on forestland.

(82) "Tree leaning over the channel" means a tree within a riparian management area if a portion of its bole crosses the vertical projection of the high water level of a stream.

(83) "Tyee Core Area" means a location with geologic conditions including thick sandstone beds with few fractures. These sandstones weather rapidly and concentrate water in shallow soils creating a higher shallow, rapidly moving landslide hazard. The Tyee Core area is located within coastal watersheds from the Siuslaw watershed south to and including the Coquille watershed, and that portion of the Umpqua watershed north of Highway 42 and west of Interstate 5. Within these boundaries, locations where bedrock is highly fractured or not of sedimentary origin as determined in the field by a geotechnical specialist are not subject to the Tyee Core area slope steepness thresholds.

(84) "Type D stream" means a stream that has domestic water use, but no fish use.

(85) "Type F stream" means a stream with fish use, or both fish use and domestic water use.

(86) "Type N stream" means a stream with neither fish use nor domestic water use.

(87) "Unit" means an operation area submitted on a notification of operation that is identified on a map and that has a single continuous boundary. Unit is used to determine compliance with ORS 527.676 (down log, snag and green live tree retention), 527.740 and 527.750 (harvest type 3 size limitation), and other forest practice rules.

(88) "Vacated roads" are roads that have been made impassable and are no longer to be used for forest management purposes or commercial forest harvesting activities.

(89) "Water bar" means a diversion ditch and/or hump in a trail or road for the purpose of carrying surface water runoff into the vegetation and duff so that it does not gain the volume and velocity which causes soil movement or erosion.

(90) "Water development" means water bodies developed for human purposes that are not part of a stream such as waste treatment lagoons, reservoirs for industrial use, drainage ditches, irrigation ditches, farm

ponds, stock ponds, settling ponds, gravel ponds, cooling ponds, log ponds, pump chances, or heli-ponds that are maintained for the intended use by human activity.

(91) "Waters of the state" include lakes, bays, ponds, impounding reservoirs, springs, wells, rivers, streams, creeks, estuaries, marshes, wetlands, inlets, canals, the Pacific Ocean within the territorial limits of the State of Oregon, and all other bodies of surface or underground waters, natural or artificial, inland or coastal, fresh or salt, public or private (except those private waters which do not combine or effect a junction with natural surface or underground waters), which are wholly or partially within or bordering the state or within its jurisdiction.

(92) "Wetland" means those areas that are inundated or saturated by surface or ground water at a frequency and duration sufficient to support, and that under normal circumstances do support, a prevalence of vegetation typically adapted for life in saturated soil conditions. Wetlands include marshes, swamps, bogs, and similar areas. Wetlands do not include water developments as defined in section (90) of this rule.

(93) "Wildlife leave trees" means trees or snags required to be retained as described in ORS 527.676 (1).

(94) "Written plan" means a document prepared by an operator, timber owner or landowner that describes how the operation is planned to be conducted.

Stat. Auth.: ORS 527.710(1)
Stats. Implemented: ORS 527.630(5), 527.674 & 527.714
Hist.: FB 31, f. 6-14-72, ef. 7-1-72; FB 39, f. 7-3-74, ef. 7-25-74; FB 1-1978, f. & ef. 1-6-78; FB 5-1978, f. & ef. 6-7-78; FB 3-1983, f. & ef. 9-13-83; FB 1-1985, f. & ef. 3-12-85; FB 2-1985(Temp), f. & ef. 4-24-85; FB 2-1987, f. 5-4-87, ef. 8-1-87; FB 4-1988, f. 7-27-88, cert. ef. 9-1-88; FB 4-1990, f. & cert. ef. 7-25-90; FB 1-1991, f. & cert. ef. 5-23-91; FB 7-1991, f. & cert. ef. 10-30-91; FB 3-1994, f. 6-15-94, cert. ef. 9-1-94; FB 5-1994, f. 12-23-94, cert. ef. 1-1-95; FB 9-1996, f. 12-2-96, cert. ef. 1-1-97, Renumbered from 629-024-0101; DOF 6-2002, f. & cert. ef. 7-1-02; DOF 13-2002, f. 12-9-02 cert. ef. 1-1-03; DOF 6-2005(Temp), f. & cert. ef. 8-2-05 thru 1-27-06; DOF 8-2005, f. 12-13-05, cert. ef. 1-1-06; DOF 7-2006(Temp), f.& cert. ef. 6-27-06 thru 12-23-06; DOF 1-2007, f. & cert. ef. 1-8-07; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-605-0150
Notification to the State Forester — When, Where and How

(1) The operator, landowner or timber owner shall notify the State Forester as required by ORS 527.670(6), at least 15 days before starting an operation.

(2) The State Forester may waive the 15 day waiting period required in section (1) of this rule, except as prohibited in ORS 527.670(9) for aerial applications of chemicals and 527.670(10) for operations requiring a written plan under 527.670(3)(a), (b) and (c). Waivers may be granted when the State Forester has already previewed the operation site or has otherwise determined the operation to have only minor potential for resource damage. Waivers shall be made in writing, and on an individual notification basis.

(3) Once an operation is actually started following proper notification of the State Forester, the operation may continue into the following calendar year without further notification under 527.670(6), provided:

(a) There are no changes to the information required on the notification;

(b) The operator gives written notice to the State Forester of their intent to continue the operation within the first two months of the following calendar year; and

(c) The operation actively continues within the first six months of the following calendar year.

(4) No notification is valid after the second calendar year, unless:

(a) The landowner or operator submits a written request to extend the notification before the end of the second calendar year;

(b) There are no changes to the information submitted on the original notification; and

(c) The State Forester approves the request.

(5) Notwithstanding sections (3) and (4) of this rule, nothing in this rule relieves an operator, landowner or timber owner of the responsibility to comply with ORS 477.625, requiring a permit to use fire or power-driven machinery; or 321.550 requiring notification of intent to harvest provided to the Department of Revenue through the department for tax collection purposes.

(6) For the purposes of ORS 527.670 a notification will be considered received only when the information required by the State Forester is complete and the necessary forms are on file at the department district or unit office responsible for the area in which the operation will take place. Notifications not properly completed shall be promptly returned to the party submitting them. Properly completed notifications submitted to an incorrect department office will be forwarded to the correct office.

(7) Notifications required by ORS 527.670(6) shall be completed in detail, on forms provided by the State Forester. The notification shall include a map to scale, or aerial photograph that is corrected for distortion, on which the boundary of the operation unit is clearly marked. When more than one type of operation activity or more than one unit is submitted on a single notification, each operation unit shall be identifiable as to the type of operation activity, by legal subdivision, and drawn on a map to scale, aerial photograph corrected for distortion, or other appropriate means. Operations involving harvesting in more than one county may not be combined on the same notification because of tax collection requirements.

(8) When operations include the application of chemicals, properly completed notifications shall include the common name of the chemicals to be used; the brand name, if known at the time of notification; the application method; and, for fertilizers, the intended application rate per acre. Public information on allowable application rates of commonly applied forest chemicals will be maintained at department field offices. Additional information on chemical applications shall be collected and recorded by operators at the time of application, and made available upon request to the State Forester, pursuant to OAR 629-620-0600.

(9) The operator, landowner or timber owner, whichever filed the original notification, shall contact the State Forester and report any subsequent change to information contained in the notification. Additions to the geographic location, however, shall require a separate notification.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.715
Hist.: FB 31, f. 6-14-72, ef. 7-1-72; FB 33, f. 6-15-73, ef. 7-1-73; FB 5-1978, f. 6-7-78; FB 2-1988, f. & cert. ef. 5-11-88; FB 9-1996, f. 12-2-96, cert. ef. 1-1-97, Renumbered from 629-024-0108; DOF 6-2002, f. & cert. ef. 7-1-02; DOF 6-2005(Temp), f. & cert. ef. 8-2-05 thru 1-27-06; DOF 8-2005, f. 12-13-05, cert. ef. 1-1-06; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-605-0160
Forest Practices Regions

The state is divided into three regions to better achieve the purposes of the forest practice rules. These regions are:

(1) Eastern Oregon Region Boundary: All land east of the summit of the Oregon Cascade Range as described by the following boundary: Beginning at a point on the Columbia River near the junction of Interstate 84 and State Highway 35, thence southerly along State Highway 35 to the north line of Section 5, T2S-R10E; thence east to the NE corner Section 5; thence southeasterly approximately 1.5 miles to a point of intersection with Forest Road No. 1720 in Section 9, T2S-R10E; thence easterly along said road and along Forest Road No. 44 to the east line of Section 12, T2S-R10E; thence southerly along the western boundaries of Wasco, Jefferson, Deschutes, and Klamath Counties to the southern boundary of Oregon.

(2) Northwest Oregon Region Boundary: All land west of the summit of the Oregon Cascade range as described in the Eastern Oregon Region Boundary, north of the south boundary of Lane County.

(3) Southwest Oregon Region Boundary: All land west of the summit of the Cascade Range as described in the Eastern Oregon Region Boundary; south of the south boundary of Lane County.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.640
Hist.: FB 10-1982, f. & ef. 10-21-82; FB 3-1994, f. 6-15-94, cert. ef. 9-1-94; FB 5-1994, f. 12-23-94, cert. ef. 1-1-95; FB 9-1996, f. 12-2-96, cert. ef. 1-1-97, Renumbered from 629-024-0112; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-605-0170
Written Plans

(1) **Definition of "Directly Affect" and "Physical Components"** For the purpose of section (4) of this rule:

(a) "Physical components" means materials such as, but not limited to, vegetation, snags, rocks and soil; and

(b) "Directly affect" means that physical components will be moved, disturbed, or otherwise altered by the operation.

(2) **Statutory Written Plans for Operations near Type F and Type D Streams**. An operator must submit to the State Forester a written plan as required by ORS 527.670(3) before conducting an operation that requires notification under OAR 629-605-0140, and that is within 100 feet of a Type F or Type D stream.

(3) **Statutory Written Plans for Operations near Wetlands larger than Eight Acres, Bogs or Important Springs in Eastern Oregon**. An operator must submit to the State Forester a written plan as required by ORS 527.670(3) before conducting an operation that requires notification under OAR 629-605-0140, and that is within 100 feet of a significant wetland that is a wetland larger than eight acres (not an estuary), a bog, or an important spring in Eastern Oregon as identified in 629-645-0000 (Riparian Management Areas and Protection Measures for Significant Wetlands).

(4) **Waiver of Statutory Written Plans**. The State Forester may waive, in writing, the requirement for a written plan described in sections (2) and (3) if the operation activity will not directly affect the physical com-

ponents of the riparian management area. Further direction of when a waiver will be granted is described in Technical Note FP10 dated September 1, 2013.

(5) **Statutory Written Plans for Operations near Wildlife Sites and Estuaries**. An operator must submit to the State Forester a written plan as required by ORS 527.670(3) before conducting an operation that requires notification under OAR 629-605-0140, and that is within 300 feet of any:

(a) Specific site involving threatened or endangered wildlife species, or sensitive bird nesting, roosting, or watering sites; as listed by approximate legal description, in a document published by the Department of Forestry titled "Cooperative Agreement Between the Board of Forestry and the Fish and Wildlife Commission, March 28, 1984."

(b) Resource site identified in OAR 629-665-0100 (Species Using Sensitive Bird Nesting, Roosting and Watering Sites), 629-665-0200 (Resource Sites Used By Threatened and Endangered Species).

(c) Significant wetland that is classified as an estuary identified in OAR 629-645-0000 (Riparian Management Areas and Protection Measures for Significant Wetlands).

(d) Nesting or roosting site of threatened or endangered species listed by the U.S. Fish and Wildlife Service or by the Oregon Fish and Wildlife Commission by administrative rule.

(6) **Statutory Written Plans and Stewardship Agreements**. The written plan requirements in section (2), (3) and (5) of this rule do not apply to operations that will be conducted pursuant to a stewardship agreement entered into under ORS 541.423.

(7) **Statutory Written Plan Requirements and Notification of Protected Resource Sites**. The State Forester shall notify the operator of the presence of any site listed in section (2), (3) or (5) of this rule at any time the State Forester determines the presence of those sites.

(8) The State Forester shall notify the operator that a written plan is required if:

(a) The operation will be within 100 feet of any sites listed in sections (2) or (3) of this rule and the operation will directly affect the physical components of a riparian management area associated with any of those sites; or

(b) The operation will be within 300 feet of any site listed in section (5) of this rule.

(9) **Statutory Written Plan Hearing Provisions**. Written plans required under sections (2), (3) or (5) of this rule shall be subject to the hearings provisions of ORS 527.700 (Appeals from orders of State Forester hearings procedure; stay of operation); and shall be subject to the provisions of 527.670 (8) through (12) (Commencement of operations; when notice and written plan required; appeal of plan) prescribing certain waiting periods and procedures.

(10) **Non-Statutory Written Plans**. An operator must submit a written plan as required by ORS 527.670(2) and the rules listed below unless the State Forester waives the written plan requirement. Written plans required by the rules listed below are not subject to the provisions of 527.700(3) or 527.670(10), (11) and (12).

(a) 629-605-0190(1) — Operating near or within sites that are listed in the "Cooperative Agreement Between the Board of Forestry and the Fish and Wildlife Commission, March 28, 1984" or sites designated by the State Forester;

(b) 629-605-0190(2) — Operating near or within habitat sites of any wildlife or aquatic species classified by the Department of Fish and Wildlife as threatened or endangered;

(c) 629-623-0700(1) — Conducting timber harvesting or road construction operations with intermediate or substantial downslope public safety risk;

(d) 629-623-0700(2) — Constructing a stream crossing fill over a debris torrent-prone stream with intermediate or substantial downslope public safety risk;

(e) 629-623-0700(3) — Locating a waste-fill area within a drainage containing debris torrent-prone streams with intermediate or substantial downslope public safety risk;

(f) 629-625-0100(2)(a) — Constructing a road where there is an apparent risk of road-generated materials entering waters of the state from direct placement, rolling, falling, blasting, landslide or debris flow;

(g) 629-625-100(2)(c) — Constructing a road within the riparian management area of a medium or large Type N stream;

(h) 629-625-0100(3) — Constructing a road on high landslide hazard locations;

(i) 629-625-0100(4) — Placing woody debris or boulders in the stream channel of a Type N stream for stream enhancement;

(j) 629-625-0320(1)(b)(B) — Constructing a permanent stream crossing fill over 15 feet deep in a Type N stream;

(k) 629-630-0200(3) — Locating a landing within the riparian management area of a medium or large Type N stream;

(l) 629-630-0700(3) — Yarding across streams classified as medium or large Type N;

(m) 629-630-0800(4)(c) — Constructing a temporary stream crossing fill over 8 feet deep in a Type N stream;

(n) 629-650-0005 — Operating within 100 feet of a large lake;

(o) 629-660-0050(1) — Removing beaver dams or other natural obstructions located farther than 25 feet from a culvert in a Type N stream;

(p) 629-665-0020(2) — Operating near a resource site requiring special protection; and

(q) 629-665-0210(1) — Operating near a Northern Spotted Owl resource site.

(11) If an operator, timber owner or landowner is required to submit a written plan to the State Forester under subsection (4) of this section:

(a) The State Forester shall review the written plan and may provide comments to the person who submitted the written plan;

(b) Provided that notice has been given as required by ORS 527.670 and OAR 629-605-0150, the operation may commence on the date the State Forester provides comments. If no comments are provided the operation may commence at any time after 14 calendar days following the date the written plan was received;

(c) Comments provided by the State Forester under paragraph (a) of this subsection, to the person who submitted the written plan are for the sole purpose of providing advice to the operator, timber owner or landowner regarding whether the operation described in the written plan is likely to comply with ORS 527.610 to 527.770 and rules adopted thereunder. Comments provided by the State Forester do not constitute an approval of the written plan or operation;

(d) If the State Forester does not comment on a written plan, the failure to comment does not mean an operation carried out in conformance with the written plan complies with ORS 527.610 to 527.770 or rules adopted thereunder nor does the failure to comment constitute a rejection of the written plan or operation;

(e) In the event that the State Forester determines that an enforcement action may be appropriate concerning the compliance of a particular operation with ORS 527.610 to 527.770 or rules adopted thereunder, the State Forester shall consider, but is not bound by, comments that the State Forester provided under this section.

(12) **Written Plan Content**. Written plans required under OAR 629-605-0170 must contain a description of how the operation is planned to be conducted in sufficient detail to allow the State Forester to evaluate and comment on the likelihood that the operation will comply with the Forest Practices Act or administrative rules.

(13) Written plans required under OAR 629-605-0170 will be considered received when complete with the following information:

(a) A map showing protected resource(s) and the harvest area; and

(b) The specific resource(s) that require protection; and

(c) The practices that may affect the protected resource(s) such as road and landing location, disposal of waste materials, felling and bucking and post operation stabilization measures; and

(d) The specific techniques and methods employed for resource protection such as road and landing design, road construction techniques, drainage systems, buffer strips, yarding system and layout; and

(e) Additional written plan content required in individual rules.

(14) In addition to the other requirements in this rule, written plans for operations within 100 feet of domestic water use portions of Type F or D streams must contain a description of the practices and methods that will be used to prevent sediment from entering waters of the state.

(15) Modification of a written plan shall be required when, based on information that was not available or was unknown at the time the original written plan was reviewed, the State Forester determines the written plan no longer addresses compliance with applicable forest practice rules. Written plans with modifications required under this section shall not be subject to the provisions of ORS 527.670(10) and (11) relating to waiting periods for written plans.

Stat. Auth.: ORS 527.710

Stats. Implemented: ORS 527.670

Hist.: FB 3-1983, f. & ef. 9-13-83; FB 3-1985, f. & ef. 6-11-85; FB 4-1988, f. 7-27-88, cert. ef. 9-1-88; FB 4-1990, f. & cert. ef. 7-25-90; FB 7-1991, f. & cert. ef. 10-30-91; FB 3-1994, f. 6-15-94, cert. ef. 9-1-94; FB 9-1996, f. 12-2-96, cert. ef. 1-1-97, Renumbered from 629-024-0113; DOF 6-2005(Temp), f. & cert. ef. 8-2-05 thru 1-27-06; DOF 8-2005, f. 12-13-05, cert. ef. 1-1-06; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-605-0173
Plans for an Alternate Practice

(1) Operators must obtain written approval of a plan for an alternate practice from the State Forester before conducting forest practices utilizing protection standards or methods different than those specified in rule or statute.

(2) Plans for an alternate practice must include sufficient information to allow the State Forester to assess the plan to determine that the practices described in the plan will yield results consistent with ORS 527.610 to 527.770 and administrative rules adopted thereunder.

(3) Plans for alternate practices proposed as part of a written plan required by ORS 527.670(3) shall be subject to the hearings provisions of 527.700(3) (Appeals from orders of State Forester hearings procedure; stay of operation); and shall be subject to the provisions of 527.670(10), (11) and (12) (Commencement of operations; when notice and written plan required; appeal of plan) prescribing certain waiting periods and procedures.

(4) An operator must comply with all provisions of an approved plan for an alternate practice.

(5) The following rules require an operator to submit a plan for an alternate practice and obtain approval from the State Forester of the plan before starting the specified practice or operation:

(a) 629-605-0100(2)(a) — Waiving or modifying the rules or statutes for a bona fide research project conducted by a federal or state agency, a college or university, or a private landowner;

(b) 629-605-0100(2)(b) — Waiving or modifying a specific practice when doing so will result in less environmental damage than if the practice is applied;

(c) 629-605-0100(2)(c) — Waiving or modifying a specific practice when doing so will improve soil, water quality, fish habitat, or wildlife habitat;

(d) 629-605-0100(2)(d) — Waiving or modifying rules to provide for public safety or to accomplish a land use change;

(e) 629-605-0100(4) — Waiving or modifying rules for resource sites when a county has an adopted program under OAR 660-016-0005 and OAR 660-016-0010 that has evaluated the resource sites;

(f) 629-605-0173(1) — Conducting forest practices utilizing protection standards or methods different than those specified in rule or statute;

(g) 629-605-0175(2) — Conducting operations that result in a single harvest type 3 unit, or combinations of harvest type 3 units, that exceed the contiguous 120 acre limit on a single ownership;

(h) 629-605-0175(7) — Waiving the harvest type 3 acreage limitations for conversions or disasters described in ORS 527.740(4);

(i) 629-605-0180(3) — Describing reasonable measures to resolve conflicts between an operation and protection of a resource site requiring a written plan under OAR 629-605-0170(1)(b) or (d);

(j) 629-605-0500 — Modifying the protection requirements for streams, lakes, wetlands and riparian management areas for reasons of forest health or because of hazards to public safety or property;

(k) 629-610-0020(3) — Waiving or modifying the reforestation requirements following a stand improvement operation where the residual stand conditions will result in enhanced long-term tree growth;

(l) 629-610-0020(10) — Modifying or waiving reforestation stocking levels if the purposes of the reforestation rules will be achieved or for a research project conducted by a public agency or educational institution;

(m) 629-610-0030(3) — Utilizing natural reforestation methods when an operation results in a reforestation requirement;

(n) 629-610-0040(3) — Extending the time allowed for reforestation when natural reforestation methods are utilized;

(o) 629-610-0050(2) — Counting hardwoods to meet more than 20% of the applicable stocking standards when an operation results in a reforestation requirement;

(p) 629-610-0060(1) — Counting non-native tree species to meet the applicable stocking standards when an operation results in a reforestation requirement;

(q) 629-610-0070(1) — Suspending the reforestation rules for the salvage or conversion of low value forest stands when participating in a forest incentive program;

(r) 629-610-0090(1) — Exempting the reforestation requirements for the purpose of developing forestland for a use that is not compatible with the maintenance of forest tree cover;

(s) 629-615-0300(5) — Modifying the protection requirements for riparian areas, aquatic areas and wetlands when the need for prescribed burning outweighs the benefits of protecting components required to be left;

(t) 629-620-0400(7)(d) — Modifying the protection requirements for aerial application of fungicides or nonbiological insecticides;

(u) 629-625-0320(3) — Modifying the culvert sizing requirements of 629-625-320(2)(a) to reduce the height of fills where roads cross wide flood plains;

(v) 629-640-0100(13) — Modifying the vegetation retention requirements in the riparian management area along a Type F stream to allow the removal of roadside trees which pose a safety hazard;

(w) 629-640-0200(14) — Modifying the vegetation retention requirements in the riparian management area along a Type D or Type N stream to allow the removal of roadside trees which pose a safety hazard;

(x) 629-640-0210(4) — Placing wood in a Type F stream or conducting other activities to meet the same purpose as leaving green trees and snags along small Type N streams subject to rapidly moving landslides.

(y) 629-640-0400(1)(a) — Utilizing site specific vegetation retention prescriptions for streams and riparian management areas;

(z) 629-645-0020(1) — Utilizing site specific vegetation retention prescriptions for significant wetlands;

(aa) 629-645-0050(3) — Modifying the vegetation retention requirements for significant wetlands for reasons of forest health;

(bb) 629-650-0040(3) — Modifying the vegetation retention requirements for lakes for reasons of forest health;

(cc) 629-665-0020(1)(b)(C) — Structural or temporal exceptions when proposed forest practices conflict with a resource site;

(dd) 629-665-0110(3) — Structural replacement of an osprey site;

(ee) 629-665-0110(4) — Temporal exceptions near an osprey site;

(ff) 629-665-0120(3) — Structural exceptions of a great blue heron site;

(gg) 629-665-0120(5) — Temporal exceptions near a great blue heron site.

Stat. Auth.: ORS 527.710
Stats.Implemented: ORS 527.670(10)-(12), 527.700(2), (5), (6), (8)&(9)
Hist.: DOF 6-2005(Temp), f. & cert. ef. 8-2-05 thru 1-27-06; DOF 8-2005, f. 12-13-05, cert. ef. 1-1-06; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-605-0180
Interim Process for Protecting Sensitive Resource Sites Requiring Written Plans

Protection practices for sites requiring written plans under OAR 629-605-0170(1)(a) or (d) shall be determined for each site as follows:

(1) The State Forester shall notify the operator and landowner of the presence of a site requiring a written plan, and request their input into the decision making process.

(2) The State Forester shall, when practical, inspect the proposed operation with the landowner or landowner's representative, the operator, and the appropriate representative of the Department of Fish and Wildlife. The State Forester shall then determine if the proposed forest practice is in conflict with the protection of the sensitive resource site.

(3) If planned forest practices are determined to conflict with protection of the sensitive resource site, the written plan must describe reasonable measures sufficient to resolve the conflict in favor of the resource site. Reasonable measures to resolve the conflict in favor of the resource site may include but are not limited to preparing and implementing a habitat management plan, obtaining approval of a plan for an alternate practice, limiting the timing of forest practices, redesigning the proposed practices in favor of site protection and excluding the forest activities outright.

(4) If planned forest practices are determined not to conflict with protection of the sensitive resource site, the written plan shall describe how the operation will be conducted in compliance with existing forest practice rules. No additional protection measures shall be required.

Stat. Auth.: ORS 527.710, 526.016(4), 527.714 & 527.715
Stats. Implemented: ORS 527.750(5), 527.765, 527.710(3)(a)(D) & 527.670(8)
Hist.: FB 4-1988, f. 7-27-88, cert. ef. 9-1-88; FB 3-1994, f. 6-15-94, cert. ef. 9-1-94; FB 9-1996, f. 12-2-96, cert. ef. 1-1-97, Renumbered from 629-024-0118; DOF 6-2005(Temp), f. & cert. ef. 8-2-05 thru 1-27-06; DOF 8-2005, f. 12-13-05, cert. ef. 1-1-06; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-610-0000
Purpose

(1) Timely reforestation of forestland is an essential factor in assuring continuous growing and harvesting of forest tree species, considering landowner objectives and consistent with the sound management of timber and other forest resources. Reforestation or other forms of revegetation are also important for the continued productivity and stabilization of soils exposed as a result of operations.

(2) OAR 629-610-0000 through 629-610-0090 shall be known as the reforestation rules.

(3) The purpose of the reforestation rules is to establish standards to ensure the timely replacement and maintenance of free to grow forest tree cover following forest operations at or above stocking levels that will use the tree growth potential of forestlands in Oregon.

(4) The reforestation rules are designed to:

(a) Define forestland subject to reforestation requirements;

(b) Describe the conditions under which reforestation shall be required;

(c) Specify the minimum number of trees per acre;

(d) Specify the maximum time period allowed for establishment of such trees after an operation reduces stocking;

(e) Describe the acceptable species for reforestation;

(f) Describe the conditions under which revegetation shall be required in lieu of reforestation; and

(g) Specify the conditions under which an exemption from the reforestation requirements may be approved.

(5) Except as described below, the reforestation rules shall become effective on January 1, 1995 and shall be applied as follows:

(a) Operations completed after January 1, 1995 must comply with the reforestation rules;

(b) Except as provided in subsection (c) operations completed before January 1, 1995 must comply with the applicable reforestation requirements of ORS 527.745 and OAR 629-024-0400 to 0404, 629-024-0500 to 0503, and 629-024-0600 to 0604 as they existed on September 6, 1994;

(c) Landowners subject to subsection (b) may request to have the reforestation rules apply to an operation at any time following January 1, 1995. The State Forester shall approve such requests so long as the landowner will fully apply the reforestation rules on the operation.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.745
Hist.: FB 5-1994, f. 12-23-94, cert. ef. 1-1-95; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-610-0020
Reforestation Stocking Standards

(1) The landowner shall increase tree stocking to a level that meets the applicable productivity-based stocking standards described in sections (4), (5) and (6) of this rule within the time limits established by OAR 629-610-0040 whenever post-operation free to grow tree stocking in all or a portion of the operation area is below the applicable stocking standards and:

(a) Trees or snags of acceptable species are harvested; or

(b) Free to grow tree stocking is reduced as a result of the operation.

(2) Reforestation is not required on those portions of the operation area:

(a) Where adequate free to grow tree stocking remains after the completion of the operation;

(b) That are not disturbed by operation activities; or

(c) On soils or sites not meeting the minimum productivity requirements of OAR 629-610-0010.

(3) The State Forester shall approve a plan for an alternate practice to waive or modify the reforestation requirements following a stand improvement operation such as a precommercial thinning, commercial thinning, overstory removal, or other partial cut harvest if the State Forester determines that the residual stand conditions after such an operation will result in enhanced long-term tree growth and there is a high probability the purpose of the reforestation rules will be achieved.

(4) For Cubic Foot Site Class I, II and III forestlands (capable of producing at least 120 cubic feet per acre per year at culmination of mean annual increment), the minimum tree stocking standards are:

(a) 200 free to grow seedlings per acre; or

(b) 120 free to grow saplings and poles per acre; or

(c) 80 square feet of basal area per acre of free to grow trees 11-inches DBH and larger; or

(d) An equivalent combination of seedlings, saplings and poles, and larger trees as calculated in section (7) of this rule.

(5) For Cubic Foot Site Class IV and V forestlands (capable of producing between 50 and 119 cubic feet per acre per year at culmination of mean annual increment), the minimum tree stocking standards are:

(a) 125 free to grow seedlings per acre; or

(b) 75 free to grow saplings and poles per acre; or

(c) 50 square feet of basal area per acre of free to grow trees 11-inches DBH and larger; or

(d) An equivalent combination of seedlings, saplings and poles, and larger trees as calculated in section (7) of this rule.

(6) For Cubic Foot Site Class VI forestlands (capable of producing between 20 and 49 cubic feet per acre per year at culmination of mean annual increment), the minimum tree stocking standards are:

(a) 100 or more free to grow seedlings per acre; or

(b) 60 free to grow saplings and poles per acre; or

(c) 40 square feet of basal area per acre of free to grow trees 11-inches DBH and larger; or

(d) An equivalent combination of seedlings, saplings and poles, and larger trees as calculated in section (7) of this rule.

(7) In both even-aged and uneven-aged stands, the stocking of residual seedlings, saplings and poles, and larger trees shall be weighted to determine stand stocking and potential reforestation requirements. For this purpose, seedlings, saplings and poles, and trees 11-inches DBH and larger are proportionally equivalent in the following ratios: 100 free to grow seedlings are equivalent to 60 free to grow saplings and poles, which are equivalent to 40 square feet of basal area of free to grow trees 11-inches DBH and larger.

(8) Live conifer trees 11-inches DBH and larger left standing in harvested areas to meet the green tree and snag retention requirements of ORS 527.676 shall be counted towards meeting the tree stocking standards if the trees are free to grow.

(9) For the purposes of determining compliance with the tree stocking requirements of the reforestation rules, tree stocking in riparian management areas within an operation area will be considered separately from stocking in the rest of the operation area.

(10) Landowners may submit plans for alternate practices that do not conform to the reforestation stocking levels established under these rules. A plan for alternate practices may be approved if the State Forester determines that there is a high probability that the purpose of the reforestation rules will be achieved, or if the plan carries out an authorized research project conducted by a public agency or educational institution.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.745
Hist.: FB 5-1994, f. 12-23-94, cert. ef. 1-1-95; DOF 6-2005(Temp), f. & cert. ef. 8-2-05 thru 1-27-06; DOF 8-2005, f. 12-13-05, cert. ef. 1-1-06; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-610-0070
Suspension of the Reforestation Rules

(1) A landowner must submit to the State Forester a plan for an alternate practice to suspend the reforestation rules for the salvage or conversion of low value forest stands, to establish forest stands that are adequately stocked and free to grow.

(2)(a) The State Forester may approve the plan for an alternate practice when the harvest area is a conversion of underproducing forestland, or a salvage of forest stands where the merchantable trees are dead or dying due to wildfire, insects, diseases or other factors beyond the landowner's control and the State Forester determines:

(A) The landowner is approved for funding from a forest incentive program, for which the State Forester is the technical advisor; and

(B) The gross harvest revenues will not exceed the total costs of harvest, taxation, and reforestation.

(b) For the purposes of this rule, "conversion of underproducing forestland" means an operation that:

(A) Is conducted on forestland that is subject to the reforestation requirements;

(B) Does not currently support the minimum number of free to grow trees required under OAR 629-610-0020;

(C) Has the objective of removing undesirable competing vegetation and establishing an adequately stocked, free to grow forest stand; and

(D) May include the incidental harvest of forest products.

(3) To determine whether subsection (2)(a)(B) of this rule is met on a harvest operation that has not started, the State Forester shall make a field observation of the harvest area to determine:

(a) The estimated merchantable volume;

(b) The value of the merchantable volume by applying current local market values; and

(c) The estimated harvest, taxation, and reforestation costs.

(4) When the State Forester is not able to determine the projected revenues and projected costs from the field observation described in subsection (3) of this rule, the State Forester may require the landowner to submit one or more of the following:

(a) A third party estimate, by species and grade, of the volumes and values of logs to be delivered to the mill;

(b) The projected costs of harvesting the forest products, including, but not limited to, harvest planning and administration, road construction and maintenance, felling and bucking, yarding, and loading and hauling;

(c) The projected severance, harvest, and income taxes;

(d) The projected costs of reforestation, including planning and administration, site preparation, trees, tree planting, tree protection, and moisture conservation; or

(e) The projected costs of any other measures necessary to establish a forest stand in an adequately stocked and free to grow condition, as specified in the reforestation rules.

(5) To determine whether subsection (2)(a)(B) of this rule is met on a harvest operation that has started, but is not yet complete, the landowner shall submit to the State Forester one or more of the following:

(a) The contracts executed to sell and harvest forest products, including but not limited to, all logging costs and receipts;

(b) All the forest products scaling summaries showing gross and net volumes, by species and corresponding mill receipts showing payment; or

(c) Any tax forms, records or reports submitted by the landowner that detail the gross and net volumes of forest products harvested, by species, plus logging and management costs used to determine harvest and severance taxes.

(6) Operations that are complete are not eligible for a suspension of the reforestation rules.

(7) The State Forester shall revoke the suspension of the reforestation rules at any time within 6 years of completing the operation if the landowner fails to establish a forest stand:

(a) According to the specifications and time lines required under the applicable forest incentive program; or

(b) In an adequately stocked and free to grow condition, as specified in the reforestation rules.

Stat. Auth.: ORS 527.670, 527.700, 527.710, 527.730, 527.765, 919.3 & 919.9
Stats. Implemented: ORS 527.74
Hist.: FB 5-1994, f. 12-23-94, cert. ef. 1-1-95, Renumbered from 629-057-5170; DOF 6-2005(Temp), f. & cert. ef. 8-2-05 thru 1-27-06; DOF 8-2005, f. 12-13-05, cert. ef. 1-1-06; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-610-0090
Exemption from Reforestation for Land Uses Not Compatible with Forest Tree Cover

(1) A landowner, through a plan for an alternate practice, may request all, or portions of, an operation area be exempted from the reforestation requirements for the purpose of developing forestland for a use that is not compatible with the maintenance of forest tree cover. Approval of a plan for an alternate practice shall be obtained for such an exemption from the State Forester and shall only be granted for the smallest land area necessary to carry out the intended change in land use. Reforestation shall be required on the portions of operation areas not directly involved in the land use change.

(2) In seeking approval of the plan for an alternate practice, the landowner shall provide written documentation to the State Forester which establishes:

(a) The specific portion of the operation area necessary for the proposed change in land use;

(b) The intended change in land use and the incompatibility of the land use with forest tree cover;

(c) The intended change in land use is authorized under local land use and zoning ordinances, and all necessary permits and approvals have been obtained, or will be obtained within 12 months following the reduction in tree stocking; and

(d) The county assessor and local planning department have been notified in writing of the proposed change in land use.

(3) Reasonable progress towards the change in land use, as determined by the State Forester, shall be made within 12 months of the completion of the operation. Evidence of reasonable progress towards a change to an agricultural use may include activities such as stump removal, cultivation, fencing, and planting or seeding of crops or pasture. Evidence of reasonable progress towards a change to a use involving building a structure may include activities such as stump removal, excavation, and construction.

(4) The change in land use shall be completed and continuously maintained within 24 months of the completion of the operation.

(5) If the change in land use cannot be accomplished within the specified time due to circumstances beyond the landowner's control, the State Forester shall extend the time to accomplish the change in land use. Such circumstances may include, but are not limited to, governmental delays in reviewing and processing permits and approvals, but do not include delays where a landowner is appealing the denial of a permit or approval if the State Forester does not have reason to believe the landowner will prevail on appeal. Extensions shall be made only upon a determination by the State Forester, based on written evidence provided by the landowner, that the landowner made reasonable attempts to comply. Landowners who need extensions are encouraged to contact the State Forester as soon as possible after the circumstances occur.

(6) The State Forester shall determine if the change in land use has been completed by:

(a) The presence or absence of improvements necessary for use of the land for the intended purpose; and

(b) Evidence of established and continuously maintained use of the land for the intended purpose.

(7) To remain exempt from the reforestation requirements the landowner shall continuously maintain the land in the new use until at least six calendar years following the completion of the operation.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.674 & 527.745
Hist.: FB 5-1994, f. 12-23-94, cert. ef. 1-1-95; DOF 6-2005(Temp), f. & cert. ef. 8-2-05 thru 1-27-06; DOF 8-2005, f. 12-13-05, cert. ef. 1-1-06; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-615-0100
Maintenance of Productivity and Related Values

(1) Operators shall plan and conduct forest operations in a manner which will provide adequate consideration to treatment of slash to protect residual stands of timber and reproduction to optimize conditions for reforestation of forest tree species, to maintain productivity of forestland, to maintain forest health, and to maintain air and water quality and fish and wildlife habitat.

(2) Operators shall dispose of or disperse unstable slash accumulations around landings to prevent their entry into streams.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.715 & 527.765
Hist.: FB 31, f. 6-14-72, ef. 7-1-72; FB 33, f. 6-15-73, ef. 7-1-73; FB 5-1978, f. & ef. 6-7-78; FB 2-1987, f. 5-4-87, ef. 8-1-87; FB 3-1994, f. 6-15-94, cert. ef. 9-1-94; FB 9-1996, f. 12-2-96, cert. ef. 1-1-97, Renumbered from 629-024-0301; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-615-0300
Prescribed Burning

(1) Prescribed burning is a tool used to achieve reforestation, maintain forest health, improve wildlife habitat and reduce wildfire hazard. Prescribed burning is to be done consistent with protection of air and water quality, and fish and wildlife habitat. The purpose of this rule is to ensure that necessary prescribed burning is planned and managed to maximize benefits and minimize potential detrimental effects.

(2) When planning and conducting prescribed burning, operators shall:

(a) Comply with the rules of Oregon's "Smoke Management Plan."

(b) Adequately protect reproduction and residual timber, humus and soil surface.

(c) Consider possible detrimental effects of prescribed burning upon riparian management areas, streams, lakes, wetlands, and water quality, and how these effects can be best minimized.

(d) Lay out the unit and use harvesting methods that minimize detrimental effects to riparian management areas, streams, lakes, wetlands, and water quality during the prescribed burning operation.

(e) Fell and yard the unit to minimize accumulations of slash in channels and within or adjacent to riparian management areas.

(f) Minimize fire intensity and amount of area burned to that necessary to achieve reforestation, forest health, or hazard reduction needs.

(3) Operators shall describe in a written plan how detrimental effects will be minimized when burning within 100 feet of Type F and Type D streams, within 100 feet of large lakes, within 100 feet of wetlands larger than eight acres (non estuaries), bogs and important springs in eastern Oregon and within 300 feet of estuaries; especially when burning on highly erosive soils, for example decomposed granite soils and slopes steeper than 60 percent.

(4) During prescribed burning operations, operators shall protect components such as live trees, snags, downed wood, and understory vegetation required to be retained by OAR 629-635-0310 through 629-650-0040. When the operator has taken reasonable precautions to protect the components, but some detrimental effects occur, the intent of the rule is met if the overall integrity of the riparian management area is maintained. Operators shall not salvage trees killed by prescribed fire in a riparian management area if the trees were retained for purposes of 629-635-0310 through 629-655-0000.

(5) When the need for prescribed burning outweighs the benefits of protecting components required to be left within the riparian area, aquatic area and wetlands, protection requirements may be modified through a plan for an alternate practice. Approval of such a plan shall consider the environmental impacts and costs of alternative treatments.

(6) (For information only) When water is to be withdrawn from the waters of the state for use in mixing pesticides or for slash burning, ORS 537.141 requires operators to notify the Water Resources Department and the Department of Fish and Wildlife. Notification to the State Forester does not satisfy this requirement.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.674 & 527.715
Hist.: FB 3-1994, f. 6-15-94, cert. ef. 9-1-94; FB 9-1996, f. 12-2-96, cert. ef. 1-1-97, Renumbered from 629-024-0302; DOF 6-2005(Temp), f. & cert. ef. 8-2-05 thru 1-27-06; DOF 8-2005, f. 12-13-05, cert. ef. 1-1-06; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-620-0000
Purpose

(1) OAR 629-620-0000 through 629-620-0800 shall be known as the chemical and other petroleum product rules. In addition to the application of chemicals, operators should be aware that certain requirements of these rules also apply to the use of other petroleum products, such as fuel and lubricants, on any forest operation.

(2) Operators are encouraged to voluntarily use integrated pest and vegetation management processes. The use of pesticides is one of a variety of integrated pest management strategies that forest landowners may implement to minimize the impact of forest pests in an environmentally and economically sound manner to meet site specific objectives. When properly used, pesticides and other chemicals can be effective tools in the growing and harvesting of forest tree species.

(3) The purpose of the forest practice chemical and other petroleum product rules is to establish requirements that will ensure:

(a) Chemicals and other petroleum products used on forestland do not occur in the soil, air, or waters of the state in quantities that would be injurious to water quality or to the overall maintenance of terrestrial wildlife or aquatic life; and

(b) The vegetative components of riparian management areas and sensitive resource sites receive protection on herbicide operations consistent with the purposes of the reforestation rules, the requirements of the sensitive resource site rules, and the vegetation retention goals of the water protection rules.

(4) All distances listed in the chemical and other petroleum product rules shall be measured horizontally.

(5) Operations involving the use of chemicals and other petroleum products on forestland are also subject to the pesticide control laws administered by the Department of Agriculture, hazardous waste laws administered by the Department of Environmental Quality, hazard communication rules administered by the Occupational Safety and Health Division, and the water use laws administered by the Water Resources Department. Maximum contaminant levels in drinking water for certain pesticides are established by the Health Division.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.715 & 527.765
Hist.: FB 9-1996, f. 12-2-96, cert. ef. 1-1-97; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-623-0100
Screening for High Landslide Hazard Locations and Exposed Population

Screening for High Landslide Hazard Locations and Exposed Population

(1) The State Forester will use further review area maps and/or other information to screen proposed operations for high landslide hazard locations that may affect exposed populations. Operators are encouraged to acquire available maps and other information and to conduct their own public safety screening.

(2) Upon notification by the State Forester, operators shall identify portions of the operation that contain high landslide hazard locations and shall also identify structures and paved public roads within further review areas below the operation area.

Stat. Auth.: ORS 527.710(10)
Stats. Implemented: ORS 527.630(5) & 527.714
Hist.: DOF 13-2002, f. 12-9-02 cert. ef. 1-1-03; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-623-0200
Exposure Categories

(1) The State Forester will verify the information provided by operators in OAR 629-623-0100 and use this information to determine the exposure category for the operation.

(2) Exposure Category A includes habitable residences, schools, and other buildings where people are normally present during periods when wet season rain storms are common.

(3) Exposure Category B includes paved public roads averaging over 500 vehicles per day as determined, if possible, during periods when wet season rain storms are common.

(4) Exposure Category C includes barns, outbuildings, recreational dwellings not included in Exposure Category A, low-use public roads, and other constructed facilities where people are not usually present when wet season rain storms are common.

Stat. Auth.: ORS 527.710(10)
Stats. Implemented: ORS 527.630(5) & 527.714
Hist.: DOF 13-2002, f. 12-9-02 cert. ef. 1-1-03; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-623-0400
Restriction of Timber Harvesting — Substantial Public Safety Risk

(1) Operators shall not remove trees from high landslide hazard locations with substantial downslope public safety risk unless a geotechnical report demonstrates to the State Forester that any landslides that might occur will not be directly related to forest practices because of very deep soil or other site-specific conditions. Removal of dead or diseased trees or trees from sites that have already failed is allowed if the operator demonstrates to the State Forester that the operation results in no increased overall downslope public safety risk.

(2) Operators shall leave a sufficient number and arrangement of trees adjacent to high landslide hazard locations to reduce the likelihood of trees retained in these locations blowing down.

Stat. Auth.: ORS 527.710(10)
Stats. Implemented: ORS 527.630(5) & 527.714
Hist.: DOF 13-2002, f. 12-9-02 cert. ef. 1-1-03; DOF 4-2008(Temp), f. 7-11-08, cert. ef. 7-18-08 thru 1-13-09; Administrative correction 1-23-09; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-625-0000
Purpose

(1) Forest roads are essential to forest management and contribute to providing jobs, products, tax base and other social and economic benefits.

(2) OAR 629-625-0000 through 629-625-0700 shall be known as the road construction and maintenance rules.

(3) The purpose of the road construction and maintenance rules is to establish standards for locating, designing, constructing and maintaining efficient and beneficial forest roads; locating and operating rock pits and quarries; and vacating roads, rock pits, and quarries that are no longer needed in manners that provide the maximum practical protection to maintain forest productivity, water quality, and fish and wildlife habitat.

(4) The road construction and maintenance rules shall apply to all forest practices regions unless otherwise indicated.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.715 & 527.765
Hist.: FB 9-1996, f. 12-2-96, cert. ef. 1-1-97; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-625-0500
Rock Pits and Quarries

(1) The development, use, and abandonment of rock pits or quarries which are located on forestland and used for forest management shall be conducted using practices which maintain stable slopes and protect water quality.

(2) Operators shall not locate quarry sites in channels.

(3) When using rock pits or quarries, operators shall prevent overburden, solid wastes, or petroleum products from entering waters of the state.

(4) Operators shall stabilize banks, headwalls, and other surfaces of quarries and rock pits to prevent surface erosion or landslides.

(5) When a quarry or rock pit is inactive or vacated, operators shall leave it in the conditions described in section (4) of this rule, shall remove from the forest all petroleum-related waste material associated with the operation, and shall dispose of all other debris so that such materials do not enter waters of the state.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.715 & 527.765
Hist.: FB 40, f. 6-5-75, ef. 7-1-75; FB 5-1978, f. & ef. 6-7-78; FB 3-1994, f. 6-15-94, cert. ef. 9-1-94; FB 9-1996, f. 12-2-96, cert. ef. 1-1-97, Renumbered from 629-024-0111; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-625-0600
Road Maintenance

(1) The purpose of this rule is to protect water quality by timely maintenance of all active and inactive roads.

(2) Operators shall maintain active and inactive roads in a manner sufficient both to provide a stable surface and to keep the drainage system operating as necessary to protect water quality.

(3) Operators shall inspect and maintain culvert inlets and outlets, drainage structures and ditches before and during the rainy season as necessary to diminish the likelihood of clogging and the possibility of washouts.

(4) Operators shall provide effective road surface drainage, such as water barring, surface crowning, constructing sediment barriers, or outsloping prior to the rainy and runoff seasons.

(5) When applying road oil or other surface stabilizing materials, operators shall plan and conduct the operation in a manner as to prevent entry of these materials into waters of the state.

(6) In the Northwest and Southwest Oregon Regions, operators shall maintain and repair active and inactive roads as needed to minimize damage to waters of the state. This may include maintenance and repair of all portions of the road prism during and after intense winter storms, as safety, weather, soil moisture and other considerations permit.

(7) Operators shall place material removed from ditches in a stable location.

(8) In order to maintain fish passage through water crossing structures, operators shall:

(a) Maintain conditions at the structures so that passage of adult and juvenile fish is not impaired during periods when fish movement normally occurs. This standard is required only for roads constructed or reconstructed after September 1994, but is encouraged for all other roads; and

(b) As reasonably practicable, keep structures cleared of woody debris and deposits of sediment that would impair fish passage.

(9) Where needed to protect water quality, as directed by the State Forester, operators shall place additional cross drainage structures on existing active roads within their ownership prior to hauling to meet the requirements of OAR 629-625-0330.

(10) Other fish passage requirements under the authority of ORS 509.580 through 509.910 and OAR 635-412-0005 through 635-412-0040 that are administered by other state agencies may be applicable to water crossing structures, including those constructed before September 1, 1994.

Stat. Auth.: ORS 527.710(2)
Stats. Implemented: ORS 527.630(3), 527.765 & 527.714
Hist.: FB 9-1996, f. 12-2-96, cert. ef. 1-1-97; DOF 12-2002, f. 12-9-02 cert. ef. 1-1-03; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-625-0650
Vacating Forest Roads

(1) The purpose of this rule is to ensure that when landowners choose to vacate roads under their control, the roads are left in a condition where road related damage to waters of the state is unlikely.

(2) To vacate a forest road, landowners shall effectively block the road to prevent continued use by vehicular traffic, and shall take all reasonable actions to leave the road in a condition where road-related damage to waters of the state is unlikely.

(3) Reasonable actions to vacate a forest road may include removal of stream crossing fills, pullback of fills on steep slopes, frequent cross ditching, and/or vegetative stabilization.

(4) Damage which may occur from a vacated road, consistent with Sections (2) and (3) of the rule, will not be subject to remedy under the provisions of the Oregon Forest Practices Act.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.715 & 527.765
Hist.: FB 9-1996, f. 12-2-96, cert. ef. 1-1-97; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-630-0800
Yarding; Ground-based Equipment Near Waters of the State

(1) Operators shall maintain the purposes and functions of vegetation required to be retained in riparian management areas, and minimize disturbances to beds and banks of streams, lakes, all wetlands larger than one-quarter acre, and retained vegetation during ground-based yarding operations.

(2) Operators shall not operate ground-based equipment within any stream channel except as allowed in the rules for temporary stream crossings.

(3) Operators shall minimize the number of stream crossings.

(4) For crossing streams that have water during the periods of the operations, operators shall:

(a) Construct temporary stream crossing structures such as log crossings, culvert installations, or fords that are adequate to pass stream flows that are likely to occur during the periods of use. Structures shall be designed to withstand erosion by the streams and minimize sedimentation.

(b) Choose locations for temporary stream crossing structures which minimize cuts and fills or other disturbances to the stream banks.

(c) Minimize the volume of material in any fills constructed at a stream crossing. Fills over eight feet deep contain such a large volume of material that they can be a considerable risk to downstream beneficial uses should the material move downstream by water. For any fill for a temporary crossing that is over eight feet deep, operators shall submit to the State Forester a written plan that includes a description of how the fills would be constructed, passage of water, and the length of time the fills would be in the stream.

(d) Design temporary structures so that fish movement is not impaired on Type F streams.

(e) Remove all temporary stream crossing structures immediately after completion of operations or prior to seasonal runoff that exceeds the water carrying capacity of the structures, whichever comes first. When removing temporary structures, operators shall place fill material where it will not enter waters of the state.

(5) For stream crossings where the channels do not contain water during the periods of the operations, operators are not required to construct temporary crossings as long as disturbances are no greater than what would occur if structures were constructed. Soil that enters the channels during the yarding operations must be removed after completion of the operation or prior to stream flow, whichever comes first. When removing such materials from the channels, operators shall place the materials in locations where they will not enter waters of the state.

(6) Operators shall construct effective sediment barriers such as water bars, dips, or other water diversion on stream crossing approaches after completion of operations, or prior to rainy season runoff, whichever comes first.

(7) Machine activity near (generally within 100 feet) streams, lakes, and other wetlands greater than one-quarter acre shall be conducted to minimize the risk of sediment entering waters of the state and preventing changes to stream channels. Operators shall only locate, construct, and maintain skid trails in riparian management areas consistent with the harvesting rules.

(8) Operators shall minimize the amount of exposed soils due to skid trails within riparian management areas. Except at stream crossings, operators shall not locate skid trails within 35 feet of Type F or Type D streams. Operators shall provide adequate distances between all skid trails and waters of the state to filter sediment from runoff water.

(9) Operators shall locate and construct skid trails so that when high stream flow occurs water from the stream will not flow onto the skid trail.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.715 & 527.765
Hist.: FB 3-1994, f. 6-15-94, cert. ef. 9-1-94, Renumbered from 629-057-2630; FB 9-1996, f. 12-2-96, cert. ef. 1-1-97, Renumbered from 629-660-0020; DOF 6-2005(Temp), f. & cert. ef. 8-2-05 thru 1-27-06; DOF 8-2005, f. 12-13-05, cert. ef. 1-1-06; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-635-0100
Purpose and Goals

(1) The leading use on private forestland is the growing and harvesting of trees, consistent with sound management of soil, air, water, fish and wildlife resources. There is a unique concentration of public resource values in and near waters of the state because these areas are critical for the overall maintenance of fish and wildlife and for maintaining water quality. Consequently, the policies of the Forest Practices Act, including encouraging economically efficient forest practices, are best achieved by focusing protection measures in riparian management areas, where the emphasis is on providing water quality and fish and wildlife habitat.

(2) OAR 629-635-0000 through 629-660-0060 are known as the "water protection rules."

(3) The purpose of the water protection rules is to protect, maintain and, where appropriate, improve the functions and values of streams, lakes, wetlands, and riparian management areas. Active management is encouraged where appropriate to meet this purpose. These functions and values include water quality, hydrologic functions, the growing and harvesting of trees, and fish and wildlife resources.

(4) Plans for alternate practices may be used to alter vegetation retention requirements in the water protection rules based on local site conditions. The plans may include but are not limited to site specific vegetation retention prescriptions as described in OAR 629-640-0400 (for streams) and 629-645-0020 (for wetlands). Operators are encouraged to:

(a) Evaluate site specific conditions in waters and riparian management areas; and

(b) Develop plans for alternate practices that will:

(A) Maintain, enhance, or restore riparian functions in streams, wetlands, and lakes; or

(B) Meet the purposes and goals of the water protection rules while better meeting operational or other objectives.

(5) General vegetation retention prescriptions for streams, lakes and wetlands apply where current vegetation conditions within the riparian management area have achieved or are likely to achieve the desired future condition in a "timely manner." Landowners are encouraged to manage stands within riparian management areas in order to grow trees in excess of what must be retained so that the opportunity is available to harvest the excess.

(6) Alternative vegetation retention prescriptions for streams allow incentives for operators to actively manage vegetation where existing vegetation conditions are not likely to achieve the desired future condition in a "timely manner."

(7) The overall goal of the water protection rules is to provide resource protection during operations adjacent to and within streams, lakes, wetlands and riparian management areas so that, while continuing to grow and harvest trees, the protection goals for fish, wildlife, and water quality are met.

(a) The protection goal for water quality (as prescribed in ORS 527.765) is to ensure through the described forest practices that, to the maximum extent practicable, non-point source discharges of pollutants resulting from forest operations do not impair the achievement and maintenance of the water quality standards.

(b) The protection goal for fish is to establish and retain vegetation consistent with the vegetation retention objectives described in OAR 629-640-0000 (streams), 629-645-0000 (significant wetlands), and 629-650-0000 (lakes) that will maintain water quality and provide aquatic habitat components and functions such as shade, large wood, and nutrients.

(c) The protection goal for wildlife is to establish and retain vegetation consistent with the vegetation retention objectives described in OAR 629-640-0000 (streams), 629-645-0000 (significant wetlands), and 629-650-0000 (lakes) that will maintain water quality and habitat components such as live trees of various species and size classes, shade, snags, downed wood, and food within riparian management areas. For wildlife species not necessarily reliant upon riparian areas, habitat in riparian management areas is also emphasized in order to capitalize on the multiple benefits of vegetation retained along waters for a variety of purposes.

Stat. Auth.: ORS 527.710, 527.630(3), 527.714 & 526.016(4)
Stats. Implemented: 527.714, 527.715 & 527.765
Hist.: FB 3-1994, f. 6-15-94, cert. ef. 9-1-94, Renumbered from 629-057-2000; DOF 8-2006, f. & cert. ef. 10-31-06; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-635-0200
Water Classification

(1) The purpose of this water classification system is to match the physical characteristics and beneficial uses of a water body to a set of appropriate protection measures.

(2) For the purposes of applying appropriate protection measures, waters of the state shall be classified as either streams, wetlands, or lakes.

(3) Streams shall be classified further according to their beneficial uses and size.

(4) Streams shall be classified into one of the following three beneficial use categories:

(a) Streams that have fish use, including fish use streams that have domestic water use, shall be classified as Type F.

(b) Streams that have domestic water use, but not fish use, shall be classified as Type D.

(c) All other streams shall be classified as Type N.

(5) For purposes of classification, a stream is considered to have domestic water use only if a water use permit has been issued by the Oregon Water Resources Department.

(6) A channel is considered to have domestic water use upstream of an intake for the distances indicated below:

(a) For domestic water use that is a community water system (as defined under OAR 333-061-0020), Type D classification shall initially apply to the length of stream that was designated as Class I under the classification system that was in effect on April 22, 1994, which is that shown on district water classification maps at the time of adoption of this rule.

(b) For domestic water use that is not a community water system, Type D classification shall be initially applied for the shortest of the following distances:

(A) The distance upstream of the intake to the farthest upstream point of summer surface flow;

(B) Half the distance from the intake to the drainage boundary; or

(C) 3000 feet upstream of the intake.

(c) Type D classification shall apply to tributaries off the main channel as long as the conditions of subsections (6)(a) and (b) of this rule apply.

(7)(a) A representative of a community water system or other domestic use water permit holder may request that the department designate additional lengths of channels upstream of a domestic water intake or reservoir as Type D. The representative or permit holder must present evidence that the additional stream protection is needed. The department will decide whether or not to extend Type D classification to these other channels based on evidence presented by the requesting party showing that protection measures associated with Type N classification would be insufficient to prevent adverse detrimental temperature increases, turbidity increases, or other adverse water quality changes at the domestic water use intake or reservoir.

(b) The process and criteria described in subsection (7)(a), and the criteria under section (6) of this rule will be used to evaluate the extent of Type D classification for new community water systems.

(c) The department will decide whether or not to extend the length of Type D classification within 30 days of the presentation of evidence.

(8) The domestic water use classification may be waived by the department at the request of a landowner who is the sole domestic water use permit holder for an intake and who owns all the land along upstream channels that would be affected by the classification related to that intake. This waiver shall not affect the classification related to downstream domestic water use intakes.

(9) A stream or lake will be considered to have fish use if inhabited at any time of the year by anadromous or game fish species or fish that are listed as threatened or endangered species under the federal or state endangered species acts.

(10) The fish use classification does not apply to waters where fish were introduced through a fish stocking permit that includes documentation that the stream had no fish prior to stocking.

(11) For the purposes of stream classification, the department will use the procedures in this section to determine if a stream has fish use.

(a) For stream segments where field surveys for fish use show that fish use ends at a natural barrier to fish use or other point that is not an artificial obstruction to fish passage, the department will designate fish use based on the survey.

(b) For stream segments where field surveys for fish use show that fish use ends at an artificial obstruction to fish passage, the department will designate fish use as continuing upstream from the artificial obstruction to the first natural barrier to fish use.

(c) For stream segments where field surveys for fish use have not been conducted, the department will designate fish use as continuing upstream from a point of known fish use and ending at the first natural barrier to fish use, without respect to any artificial obstructions to fish passage. An operator may request that the department conduct a fish presence survey to verify this designation of fish use in stream segments associated with an operation scheduled to start between 12 and 24 months after the request.

(A) The department will make a good faith effort to conduct the requested surveys and will prioritize its survey work taking into account landowners without the financial or technical resources to conduct the surveys themselves.

(B) As an option, the landowner may conduct the fish presence survey.

(C) If neither the landowner nor the department is able to conduct the survey before the operation begins, the Type F classification applies up to the first natural barrier to fish use.

(d) To be used for stream classification under this section, field surveys for fish use must be conducted according to the protocol in "Surveying Forest Streams for Fish Use," published by the Oregon Department of Forestry and the Oregon Department of Fish and Wildlife.

(e) The department may use other information to determine the upstream extent of fish use including but not limited to field surveys for fish use by landowners or other entities, and local knowledge of stream conditions, natural barriers to fish use, or fish presence.

(f) An operator may request an exception to Type F stream classification above an artificial obstruction to fish passage that is documented by field survey as the end of fish use. The department will grant the request upon determining that the artificial obstruction is likely to continue to prevent fish passage for a period of time exceeding that needed to regrow trees to a size that would provide key pieces of large wood.

(g) When an exception to Type F stream classification is made above an artificial obstruction to fish passage, the department will classify the

stream as either Type D or Type N as appropriate and operators must apply the corresponding vegetation retention requirements.

(h) For the purposes of ORS 215.730(1)(b)(C), Type N streams are equivalent to "Class II streams."

(12) For each of the three beneficial use categories (Type F, Type D, and Type N), streams shall be categorized further according to three size categories: large, medium, and small. The size categories are based on average annual flow.

(a) Small streams have an average annual flow of two cubic feet per second or less.

(b) Medium streams have an average annual flow greater than 2 and less than 10 cubic feet per second.

(c) Large streams have an average annual flow of 10 cubic feet per second or greater.

(13) The assignment of size categories to streams on forestland will be done by the department as follows:

(a) The department will index average annual flow to the upstream drainage area and average annual precipitation. The methodology is described in Technical Note FP1 dated April 21, 1994.

(b) Actual measurements of average annual flow may substitute for the calculated flows described in the technical note.

(c) Any stream with a drainage area less than 200 acres shall be assigned to the small stream category regardless of the flow index calculated in subsection (13)(a).

(14) Wetlands shall be classified further as indicated below:

(a) The following types of wetlands are classified as "significant wetlands":

(A) Wetlands that are larger than 8 acres;

(B) Estuaries;

(C) Bogs; and

(D) Important springs in eastern Oregon.

(b) Stream-associated wetlands that are less than 8 acres are classified according to the stream with which they are connected.

(c) All other wetlands, including seeps and springs are classified according to their size as either "other wetlands greater than one-quarter acre" or "other wetlands less than one-quarter acre."

(15) Lakes shall be classified further as indicated below:

(a) Lakes greater than 8 acres are classified as "large lakes."

(b) All other lakes are classified as "other lakes."

Stat. Auth.: ORS 527.710, 527.630(3), 527.714 & 526.016(4)
Stats. Implemented: 527.714, 527.715 & 527.765
Hist.: FB 3-1994, f. 6-15-94, cert. ef. 9-1-94, Renumbered from 629-057-2100; DOF 9-2006, f. & cert. ef. 10-31-06; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-640-0000
Vegetation Retention Goals for Streams; Desired Future Conditions

(1) The purpose of this rule is to describe how the vegetation retention measures for streams were determined, their purpose and how the measures are implemented. The vegetation retention requirements for streams described in OAR 629-640-0100 through 629-640-0400 are designed to produce desired future conditions for the wide range of stand types, channel conditions, and disturbance regimes that exist throughout forestlands in Oregon.

(2) The desired future condition for streamside areas along fish use streams is to grow and retain vegetation so that, over time, average conditions across the landscape become similar to those of mature streamside stands. Oregon has a tremendous diversity of forest tree species growing along waters of the state and the age of mature streamside stands varies by species. Mature streamside stands are often dominated by conifer trees. For many conifer stands, mature stands occur between 80 and 200 years of stand age. Hardwood stands and some conifer stands may become mature at an earlier age. Mature stands provide ample shade over the channel, an abundance of large woody debris in the channel, channel-influencing root masses along the edge of the high water level, snags, and regular inputs of nutrients through litter fall.

(3) The rule standards for desired future conditions for fish use streams were developed by estimating the conifer basal area for average unmanaged mature streamside stands (at age 120) for each geographic region. This was done by using normal conifer yield tables for the average upland stand in the geographic region, and then adjusting the basal area for the effects of riparian influences on stocking, growth and mortality or by using available streamside stand data for mature stands.

(4) The desired future condition for streamside areas that do not have fish use is to have sufficient streamside vegetation to support the functions and processes that are important to downstream fish use waters and domestic water use and to supplement wildlife habitat across the landscape. Such functions and processes include: maintenance of cool water temperature and other water quality parameters; influences on sediment production and bank stability; additions of nutrients and large conifer organic debris; and provision of snags, cover, and trees for wildlife.

(5) The rule standards for desired future conditions for streams that do not have fish use were developed in a manner similar to that used for fish use streams. In calculating the rule standards, other factors used in developing the desired future condition for large streams without fish use and all medium and small streams included the effects of trees regenerated in the riparian management area during the next rotation and desired levels of instream large woody debris.

(6) For streamside areas where the native tree community would be conifer dominated stands, mature streamside conditions are achieved by retaining a sufficient amount of conifers next to large and medium sized fish use streams at the time of harvest, so that halfway through the next rotation or period between harvest entries, the conifer basal area and density is similar to mature unmanaged conifer stands. In calculating the rule standards, a rotation age of 50 years was assumed for even-aged management and a period between entries of 25 years was assumed for uneven-aged management. The long-term maintenance of streamside conifer stands is likely to require incentives to landowners to manage streamside areas so that conifer reforestation occurs to replace older conifers over time.

(7) Conifer basal area and density targets to produce mature stand conditions over time are outlined in the general vegetation retention prescriptions. In order to ensure compliance with state water quality standards, these rules include requirements to retain all trees within 20 feet and understory vegetation within 10 feet of the high water level of specified channels to provide shade.

(8) For streamside areas where the native tree community would be hardwood dominated stands, mature streamside conditions are achieved by retaining sufficient hardwood trees. As early successional species, the long-term maintenance of hardwood streamside stands will in some cases require managed harvest using site specific vegetation retention prescriptions so that reforestation occurs to replace older trees. In order to ensure compliance with state water quality standards, these rules include requirements in the general vegetation retention prescription to retain all trees within 20 feet and understory vegetation within 10 feet of the high water level of specified channels to provide shade.

(9) In many cases the desired future condition for streams can be achieved by applying the general vegetation retention prescriptions, as described in OAR 629-640-0100 and 629-640-0200. In other cases, the existing streamside vegetation may be incapable of developing into the future desired conditions in a "timely manner." In this case, the operator can apply an alternative vegetation retention prescription described in 629-640-0300 or develop a site specific vegetation retention prescription described in 629-640-0400. For the purposes of the water protection rules, "in a timely manner" means that the trees within the riparian management area will meet or exceed the applicable basal area target or vegetation retention goal during the period of the next harvest entry that would be normal for the site. This will be 50 years for many sites.

(10) Where the native tree community would be conifer dominant stands, but due to historical events the stand has become dominated by hardwoods, in particular, red alder, disturbance is allowed to produce conditions suitable for the re-establishment of conifer. In this and other situations where the existing streamside vegetation is incapable of developing characteristics of a mature streamside stand in a "timely manner," the desired action is to manipulate the streamside area and woody debris levels at the time of harvest (through an alternative vegetation retention prescription or site specific vegetation retention prescription) to attain such characteristics more quickly.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.765 & 919(9)
Hist.: FB 3-1994, f. 6-15-94, cert. ef. 9-1-94, Renumbered from 629-057-2220; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-640-0100
General Vegetation Retention Prescription for Type F Streams

(1)(a) Operators shall apply the vegetation retention requirements described in this rule to the riparian management areas of Type F streams.

(b) Segments of Type F streams that are different sizes within an operation shall not be combined or averaged together when applying the vegetation retention requirements.

(c) Trees left to meet the vegetation retention requirements for one stream type shall not count towards the requirements of another stream type.

(2) Operators shall retain:

(a) All understory vegetation within 10 feet of the high water level;

(b) All trees within 20 feet of the high water level; and

(c) All trees leaning over the channel.

(3) Operators shall retain within riparian management areas and streams all downed wood and snags that are not safety or fire hazards. Snags felled for safety or fire hazard reasons shall be retained where they are felled unless used for stream improvement projects.

(4) Notwithstanding the requirements of section (2) of this rule, vegetation, snags and trees within 20 feet of the high water level of the stream may be felled, moved or harvested as allowed in other rules for road construction, yarding corridors, temporary stream crossings, or for stream improvement.

(5) Operators shall retain at least 40 live conifer trees per 1000 feet along large streams and 30 live conifer trees per 1000 feet along medium streams. This includes trees left to meet the requirements described in section (2) of this rule. Conifers must be at least 11 inches DBH for large streams and 8 inches DBH for medium streams to count toward these requirements.

(6) Operators shall retain trees or snags six inches or greater DBH to meet the following requirements (this includes trees left to meet the requirements of sections (2) and (5) of this rule):

(a) If the live conifer tree basal area in the riparian management area is greater than the standard target shown in Table 2 where the harvest unit will be a harvest type 2 or type 3 unit or Table 3 where the harvest unit will be a harvest type 1, partial harvest, or thinning, operators shall retain live conifer trees of sufficient basal area to meet the standard target.

(b) If the live conifer tree basal area in the riparian management area is less than the standard target (as shown in Table 2 where the harvest unit will be a harvest type 2 or type 3 unit, or Table 3 where the harvest unit will be a harvest type 1, partial harvest, or thinning) but greater than one-half the standard target shown in Table 2, operators shall retain all live conifer trees six inches DBH or larger in the riparian management area (up to a maximum of 150 conifers per 1000 feet along large streams, 100 conifers per 1000 feet along medium streams, and 70 conifers per 1000 feet along small streams).

(c) If live conifer tree basal area in the riparian management area is less than one-half the standard target shown in Table 2:

(A) Operators may apply an alternative vegetation retention prescription as described in OAR 629-640-0300 where applicable, or develop a site specific vegetation retention prescription as described in 629-640-0400; or

(B) Operators shall retain all conifers in the riparian management area and all hardwoods within 50 feet of the high water level for large streams, within 30 feet of the high water level for medium streams, and within 20 feet of the high water level for small streams.

(7) In the Coast Range, South Coast, Interior, Western Cascade, and Siskiyou geographic regions, hardwood trees and snags six inches or greater DBH may count toward the basal area requirements in subsection (6)(a) of this rule as follows:

(a) All cottonwood and Oregon ash trees within riparian management areas that are beyond 20 feet of the high water level of large Type F streams, may count toward the basal area requirements.

(b) Up to 10 percent of the basal area requirement may be comprised of sound conifer snags at least 30 feet tall and other large live hardwood trees, except red alder, growing in the riparian management area more than 20 feet from the high water level and at least 24 inches DBH.

(8) In the Eastern Cascade and Blue Mountain geographic regions, hardwood trees, dying or recently dead trees and snags six inches or greater DBH may count toward the basal area requirements in subsection (6)(a) of this rule as follows:

(a) The basal area of retained live hardwood trees may count toward meeting the basal area requirements.

(b) Up to 10 percent of the basal area retained to meet the basal area requirement may be comprised of sound conifer snags at least 30 feet tall.

(c) For small Type F streams, the maximum required live conifer tree basal area that must be retained to meet the standard target is 40 square feet. The remaining basal area required may come from retained snags, dying or recently dead trees, or hardwoods if available within the riparian management area.

(9) Notwithstanding the requirements indicated in this rule, operators may conduct precommercial thinning and other release activities to maintain the growth and survival of conifer reforestation within riparian management areas. Such activities shall contribute to and be consistent with enhancing the stand's ability to meet the desired future condition.

(10) When determining the basal area of trees, the operator may use the average basal area for a tree's diameter class, as shown in Table 4, or determine an actual basal area for each tree. The method for determining basal area must be consistent throughout the riparian management area.

(11)(a) For large and medium Type F streams, live conifer trees retained in excess of the active management target shown in Table 2 and hardwoods retained beyond 20 feet of the high water level of the stream that otherwise meet the requirements for leave trees may be counted toward requirements for leave trees within harvest type 2 or harvest type 3 units (pursuant to ORS 527.676).

(b) For small Type F streams, all retained live trees that otherwise meet the requirements for leave trees may count toward requirements for leave trees within harvest type 2 or harvest type 3 units (pursuant to ORS 527.676).

(12) Trees on islands with ground higher than the high water level may be harvested as follows:

(a) If the harvest unit is solely on an island, operators shall apply all the vegetation retention requirements for a large Type F stream described in this rule to a riparian management area along the high water level of the channels forming the island.

(b) Otherwise, operators shall retain all trees on islands within 20 feet of the high water level of the channels forming the island and all trees leaning over the channels. In this case, conifer trees retained on islands may count toward the basal area requirement for adjacent riparian management areas so long as the trees are at least 11 inches DBH for large streams and eight inches DBH for medium streams.

(13) When applying the vegetation retention requirements described in this rule to the riparian management areas, if an operator cannot achieve the required retention without leaving live trees on the upland side of a road that may be within the riparian management area and those trees pose a safety hazard to the road and will provide limited functional benefit to the stream, the State Forester may approve a plan for an alternate practice to modify the retention requirements on a site specific basis.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 527.710

Stats. Implemented: ORS 527.715 & 527.765

Hist.: FB 3-1994, f. 6-15-94, cert. ef. 9-1-94, Renumbered from 629-057-2230; FB 9-1996, f. 12-2-96, cert. ef. 1-1-97; DOF 6-2005(Temp), f. & cert. ef. 8-2-05 thru 1-27-06; DOF 8-2005, f. 12-13-05, cert. ef. 1-1-06; DOF 7-2006(Temp), f. & cert. ef. 6-27-06 thru. 12-23-06; Administrative correction 1-16-07; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-640-0105

Placing Large Wood Key Pieces in Type F Streams to Improve Fish Habitat

(1) Placement of large wood key pieces in a Type F stream to improve fish habitat that is conducted in conjunction with a forest operation is subject to the regulations in the Oregon Forest Practices Act and the forest practice rules.

(2) The goal of placing large wood key pieces is to deliver wood that is relatively stable, but can reconfigure to a limited degree and work with the natural stream flow to restore and maintain habitat for aquatic species. When placing large wood key pieces in conjunction with an operation, an operator shall design and implement the project to:

(a) Rely on the size of wood for stability and exclude the use of any type of artificial anchoring;

(b) Emulate large wood delivery configurations that occur from natural riparian processes over time;

(c) Restore and maintain natural aquatic habitat over time rather than rely on constructed habitat structures; and

(d) Meet the standards established in "Guide to Placement of Wood, Boulders and Gravel for Habitat Restoration," developed by the Oregon Department of Forestry, Oregon Department of Fish and Wildlife, Oregon Department of State Lands, and Oregon Watershed Enhancement Board, January 2010.

Stat. Auth.: ORS 527.710(1)

Stats. Implemented: ORS 527.765, 527.674, 527.714 & 527.715

Hist.: DOF 1-2007, f. & cert. ef. 1-8-07; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-640-0200

General Vegetation Retention Prescription for Type D and Type N Streams

(1)(a) Operators shall apply the vegetation retention requirements described in this rule to the riparian management areas of Type D and Type N streams.

(b) Segments of Type D or Type N streams that may be of a different size within an operation shall not be combined or averaged together when applying the vegetation retention requirements.

(c) Trees left to meet the vegetation retention requirements for one stream type shall not count toward the requirements of another stream type.

(2) Operators shall retain along all Type D, and large and medium Type N streams:

(a) All understory vegetation within 10 feet of the high water level;

(b) All trees within 20 feet of the high water level; and

(c) All trees leaning over the channel.

(3) Operators shall retain all downed wood and snags that are not safety or fire hazards within riparian management areas and streams. Snags felled for safety or fire hazard reasons shall be retained where they are felled unless used for stream improvement projects.

(4) Notwithstanding the requirements of section (2), vegetation, snags and trees within 20 feet of the high water level of the stream may be felled, moved or harvested as allowed in the rules for road construction, yarding corridors, temporary stream crossings, or for stream improvement.

(5) Operators shall retain at least 30 live conifer trees per 1000 feet along large Type D and Type N streams and 10 live conifer trees per 1000 feet along medium Type D and Type N streams. This includes any trees left to meet the requirements described in section (2) of this rule. Conifers must be at least 11 inches DBH for large streams and eight inches DBH for medium streams to count toward these requirements.

(6) Operators shall retain all understory vegetation and non-merchantable conifer trees (conifer trees less than six inches DBH) within 10 feet of the high water level on each side of small perennial Type N streams indicated in Table 5.

(a) The determination that a stream is perennial shall be made by the State Forester based on a reasonable expectation that the stream will have summer surface flow after July 15.

(b) The determination in subsection (6)(a) of this rule can be made based on a site inspection, data from other sources such as landowner information, or by applying judgment based upon stream flow patterns experienced in the general area.

(c) Operators are encouraged whenever possible to retain understory vegetation, non-merchantable trees, and leave trees required within harvest type 2 or harvest type 3 units (pursuant to ORS 527.676) along all other small Type N streams within harvest units.

(7) Operators shall retain trees six inches or greater DBH to meet the following requirements (this includes trees left to meet the requirements of sections (2) and (5) of this rule):

(a) If the live conifer tree basal area in the riparian management area is greater than the standard target shown in Table 6 where the harvest will be a harvest type 2 or type 3 unit or in Table 7 where the harvest unit is a harvest type 1, partial harvest, or thinning, operators shall retain along all Type D, and medium and large Type N streams live conifer trees of sufficient basal area to meet the standard target.

(b) If the live conifer tree basal area in the riparian management area is less than the standard target (as shown in Table 6 where the harvest will be a harvest type 2 or type 3 unit or Table 7 where the harvest unit is a harvest type 1, partial harvest, or thinning), but greater than one-half the standard target shown in Table 6, operators shall retain along all Type D, and medium and large Type N streams all conifers 6 inches DBH or larger in the riparian management area (up to a maximum of 100 conifers per 1000 feet along large streams, and 70 conifers per 1000 feet along medium streams).

(c) If the live conifer tree basal area in the riparian management area is less than one-half the standard target shown in Table 6:

(A) Operators may apply an alternative vegetation retention prescription as described in OAR 629-640-0300, where applicable, or develop a site specific vegetation retention prescription as described in OAR 629-640-0400; or

(B) Operators shall retain along all Type D, and medium and large Type N streams all conifers in the riparian management area and all hardwoods within 30 feet of the high water level for large streams and within 20 feet of the high water level for medium streams.

(8) In the Coast Range, South Coast, Interior, Western Cascade, and Siskiyou geographic regions, hardwood trees and snags six inches or greater DBH may count toward the basal area requirements in subsection (7)(a) of this rule as follows:

(a) All cottonwood and Oregon ash trees within riparian management areas that are beyond 20 feet of the high water level of large Type D and N streams, may count toward the basal area requirements.

(b) For large Type D and N streams, up to 10 percent of the basal area requirement may be comprised of sound conifer snags at least 30 feet tall and other large live hardwood trees, except red alder, growing in the riparian management area more than 20 feet from the high water level and at least 24 inches DBH.

(c) For medium Type D and N streams:

(A) Up to 30 square feet of basal area per 1000 feet of stream may be comprised of hardwood trees.

(B) Up to five percent of the basal area retained may be comprised of sound conifer snags that are at least 30 feet tall.

(9) In the Eastern Cascade and Blue Mountain geographic regions:

(a) The basal area of all retained live hardwood trees may count toward meeting the basal area requirements.

(b) For large Type D and N streams, up to 10 percent of the basal area requirement may be comprised of sound conifer snags at least 30 feet tall.

(c) For medium Type D and N streams, up to five percent of the basal area retained may be comprised of sound conifer snags that are at least 30 feet tall.

(10) Notwithstanding the requirements indicated in this rule, operators may conduct precommercial thinning and other release activities to maintain the growth and survival of conifer reforestation within riparian management areas. Such activities shall contribute to and be consistent with enhancing the stand's ability to meet the desired future condition.

(11) When determining the basal area of trees along streams in a harvest unit, operators may use the average basal area for a tree's diameter class, as shown in Table 4 in OAR 629-640-0100, or determine an actual basal area for each tree. The method for determining basal area must be consistent throughout the riparian management area.

(12) All live trees retained along Type D and N streams that otherwise meet the requirements for leave trees may count toward requirements for leave trees within harvest type 2 or harvest type 3 units (pursuant to ORS 527.676).

(13) Trees on islands with ground higher than the high water level may be harvested as follows:

(a) If the harvest unit is solely on an island, operators shall apply all the vegetation retention requirements for a large Type F stream described in this rule to a riparian management area along the high water level of the channels forming the island.

(b) Otherwise, operators shall retain all trees on islands within 20 feet of the high water level of the channels forming the island and all trees leaning over the channels. In this case, conifer trees retained on islands may count toward the basal area requirement for adjacent riparian management areas so long as the trees are at least 11 inches DBH for large streams and 8 inches DBH for medium streams.

(c) All merchantable trees may be harvested from islands within small Type N streams.

(14) When applying the vegetation retention requirements described in this rule to the riparian management areas, if an operator cannot achieve the required retention without leaving live trees on the upland side of a road that may be within the riparian management area and those trees pose a safety hazard to the road and will provide limited functional benefit to the stream, the operator may submit a plan for an alternate practice to the State Forester to modify the retention requirements on a site specific basis.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 527

Stats. Implemented: ORS 527.674, 527.715 & 527.765

Hist.: FB 3-1994, f. 6-15-94, cert. ef. 9-1-94, Renumbered from 629-057-2250; FB 9-1996, f. 12-2-96, cert. ef. 1-1-97; DOF 6-2005(Temp), f. & cert. ef. 8-2-05 thru 1-27-06; DOF 8-2005, f. 12-13-05, cert. ef. 1-1-06; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-645-0000

Riparian Management Areas and Protection Measures for Significant Wetlands

(1)(a) The purpose of these rules is to protect the functions and values of significant wetlands, including wetlands larger than eight acres, estuaries, bogs and important springs in eastern Oregon on forestlands.

(b) Significant wetlands on forestlands provide a wide range of functions and values, including those related to water quality, hydrologic function, fish and other aquatic organisms, and wildlife.

(c) Estuaries are unique systems because they form transitions between terrestrial, marine, and freshwater environments. Because of this link, estuarine systems are among the most biologically productive in the world. Estuaries support many resident species. Estuaries also provide food, spawning area, and shelter for numerous other species at critical points in their life cycles. Removal of shoreline trees reduces the overall productivity of the estuary by reducing leaf and litter fall, thus depriving the estuary of substrate, and by removing feeding and resting habitat for birds and small mammals.

(d) Bog communities are a result of specific hydrologic, soil, and nutrient conditions. Bogs are usually saturated, low in nutrients, and highly acidic. Changes in runoff, sediment loading, and nutrient loading can alter the plant community composition. The peat soils have evolved over time. Compaction damages plant communities and may encourage the

invasion of exotic species. Harvesting may disrupt shade tolerant vegetation, alter plant community characteristics, and hasten succession. Compaction, saturated conditions, and poor nutrient status make reforestation difficult.

(e) In arid parts of eastern Oregon, springs provide a critical source of water. These important springs have established wetland vegetation, flow year round in most years, and are used by a concentration of diverse animal species. By reason of sparse occurrence, important springs have a major influence on the distribution and abundance of upland species. Important springs shall be identified by the State Forester.

(2)(a) The goals of significant wetland protection are to maintain the functions and values of significant wetlands on forestlands over time, and to ensure that forest practices do not lead to resource site destruction or reduced productivity, while at the same time ensuring the continuous growth and harvest of forest tree species. To accomplish these goals, the rules focus on the protection of soil, hydrologic functions, and specified levels of vegetation.

(b) The intent of the rules is to minimize soil disturbance and to minimize disturbance to the natural drainage patterns of the significant wetland.

(c) Vegetation retention (including understory vegetation, snags, downed wood, and live trees) is needed to prevent erosion and sedimentation into the significant wetland, minimize soil disturbance and hydrologic changes, and to maintain components of the vegetation structure to provide for other benefits, particularly fish and wildlife values.

(3) Significant wetlands other than estuaries, bogs or important springs in eastern Oregon shall have riparian management areas extending 100 feet from the wetlands. When an operation is proposed within 300 feet of an estuary or within 100 feet of a wetland larger than eight acres (non estuary), bog or important spring in eastern Oregon, the resource site evaluation process in OAR 629-665-0020 shall be followed by the landowner, operator or timber owner. If the proposed operation conflicts with the significant wetland, the operator shall submit a written plan to the State Forester before starting operations. The written plan shall comply with the requirements of 629-605-0170, Written Plans.

(4) For all significant wetlands, operators shall provide the following to the wetlands and riparian management areas:

(a) Live tree retention (OAR 629-645-0010);

(b) Soil and hydrologic function protection (OAR 629-645-0030);

(c) Understory vegetation retention (OAR 629-645-0040); and

(d) Snag and down wood retention (OAR 629-645-0050).

(5) For forested significant wetlands, written plans must address reforestation.

(6) When an operation is proposed within 300 feet of an estuary, bog or important spring in eastern Oregon, the State Forester shall determine the riparian management area during the resource site inspection required by OAR 629-665-0020. Riparian management areas shall extend outward 100 to 200 feet from the estuary, 50 to 100 feet from the bog, or 50 to 100 feet from the important spring in eastern Oregon. The distance determination of the State Forester shall depend on:

(a) Stocking level of the timber stand adjacent to the estuary, bog or spring;

(b) Ability of the area to withstand windthrow;

(c) Size of the estuary, bog or spring. As the size increases, the size of the riparian management area shall increase; and

(d) For bogs and springs only, topography and erodibility of adjacent uplands.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.715 & 527.765
Hist.: FB 3-1994, f. 6-15-94, cert. ef. 9-1-94, Renumbered from 629-057-2300; FB 9-1996, f. 12-2-96, cert. ef. 1-1-97; DOF 6-2002, f. & cert. ef. 7-1-02; DOF 6-2005(Temp), f. & cert. ef. 8-2-05 thru 1-27-06; DOF 8-2005, f. 12-13-05, cert. ef. 1-1-06; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-645-0030
Soil and Hydrologic Function Protection for Significant Wetlands

(1) In significant wetlands and their riparian management areas, operators shall protect soil from disturbances that result in impaired water quality, hydrologic functions, or soil productivity. Operators shall protect hydrologic functions by minimizing disturbances and shall prevent accelerating the natural conversion of the wetland to uplands.

(2) The written plan required under OAR 629-605-0170 shall describe how the operation will be conducted to prevent adverse effects on water quality, hydrologic functions or soil productivity. The following practices shall be addressed in written plans when they are proposed in significant wetlands:

(a) Filling within wetlands;

(b) Machine activity within wetlands; and

(c) Road construction within wetlands.

(3) Operators shall not drain significant wetlands.

(4) Notwithstanding subsection (3) of this rule, minor drainage for reforestation is allowed. Any drainage for reforestation must be designed so the significant wetland is not converted to an upland.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.674, 527.715 & 527.765
Hist.: FB 3-1994, f. 6-15-94, cert. ef. 9-1-94, Renumbered from 629-057-2330; FB 9-1996, f. 12-2-96, cert. ef. 1-1-97; DOF 6-2005(Temp), f. & cert. ef. 8-2-05 thru 1-27-06; DOF 8-2005, f. 12-13-05, cert. ef. 1-1-06; DOF 8-2005, f. 12-13-05, cert. ef. 1-1-06; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-645-0040
Understory Vegetation Retention for Significant Wetlands

(1) The purpose of retaining understory vegetation is to provide soil stability and bank stability in and along significant wetlands, to maintain cover and shade for wildlife habitat and aquatic habitat, and to protect water quality.

(2) To achieve the purpose of understory retention, the operator shall limit disturbance of understory vegetation within significant wetlands and their riparian management areas to the minimum necessary to remove timber harvested from the area and achieve successful reforestation.

(3) The written plan required in OAR 629-605-0170 for operations within 300 feet of estuaries and 100 feet of wetlands larger than eight acres (non-estuaries), bogs and important springs in eastern Oregon shall describe how disturbance to the understory vegetation will be minimized during harvest or site preparation for reforestation.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.710 & 527.765
Hist.: FB 3-1994, f. 6-15-94, cert. ef. 9-1-94, Renumbered from 629-057-2340; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-645-0050
Snag and Downed Wood Retention for Significant Wetlands

(1) For significant wetlands, operators shall retain all snags and downed trees within the wetlands and the applicable riparian management areas.

(2) Notwithstanding subsection (1) of this rule, any snag defined to be a safety hazard under the safety requirements found in OAR 437, division 7, Forest Activities, or determined to be a fire hazard by the State Forester, may be felled. Any snag felled because of a safety or fire hazard shall be left unyarded.

(3) The retention requirements in subsection (1) of this rule may be modified for reasons of forest health for trees that are dying or recently dead because of fire, insect or disease epidemics, or other catastrophic events when addressed in a plan for an alternate practice approved by the State Forester.

(4) Snags and downed wood left pursuant to subsection (1) of this rule may not be counted toward the requirements of ORS 527.676.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.674, 527.715 & 527.765
Hist.: FB 3-1994, f. 6-15-94, cert. ef. 9-1-94, Renumbered from 629-057-2350; FB 9-1996, f. 12-2-96, cert. ef. 1-1-97; DOF 6-2005(Temp), f. & cert. ef. 8-2-05 thru 1-27-06; DOF 8-2005, f. 12-13-05, cert. ef. 1-1-06; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-650-0000
Riparian Management Areas and Protection Measures for Lakes

(1) The purpose of this rule is to protect the functions and values of lakes. Lakes on forestlands provide a wide range of functions and values, including those related to water quality, hydrologic functions, aquatic organisms, fish and wildlife.

(2) Operators shall protect riparian management areas extending:

(a) 100 feet from the high water level of large lakes; and

(b) 50 feet from the high water level of other lakes that have fish use or other lakes that are equal to or greater than one-half acre in size.

(c) No riparian management area is required for other lakes that do not have fish and that are less than one-half acre.

(3) For all lakes with riparian management areas, operators shall provide the following to the riparian management areas and the aquatic areas:

(a) Live tree retention (OAR 629-650-0010);

(b) Soil and hydrologic function protection (OAR 629-650-0020);

(c) Understory vegetation retention (OAR 629-650-0030); and

(d) Snag and down wood retention (OAR 629-650-0040).

(4) For all lakes not having riparian management areas, the lakes shall be protected as other wetlands (OAR 629-655-0000).

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.710 & 527.765
Hist.: FB 3-1994, f. 6-15-94, cert. ef. 9-1-94, Renumbered from 629-057-2400; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-650-0005
Written Plans for Operations Near Large Lakes

An operator shall submit a written plan to the State Forester before conducting an operation that requires notification under OAR 629-605-0140 and that is within 100 feet of a large lake.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.710 & 527.670 2)
Hist.: DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-660-0050
Beaver Dams or Other Natural Obstructions

(1) Except as needed for road maintenance, operators must submit a written plan to the State Forester prior to the removal of beaver dams and other natural obstructions from waters of the state during forest operations. Removal of any beaver dam that is within 25 feet of a culvert shall be considered to be needed for road maintenance.

(2) A written plan for removal of a beaver dam or obstruction must demonstrate:

(a) A beaver dam or obstruction threatens existing forests or plantations;

(b) Beaver dam removal is part of a beaver population control program approved by the Oregon Department of Fish and Wildlife; or

(c) Retaining the beaver dam or obstruction would result in greater environmental harm than benefit.

(3) Sediment releases and downstream channel scouring can occur when beaver dams are removed. Operators are encouraged to use techniques that result in a gradual release of water when a dam is removed.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.674, 527.710 & 527.765
Hist.: FB 3-1994, f. 6-15-94, cert. ef. 9-1-94, Renumbered from 629-057-2660; DOF 6-2005(Temp), f. & cert. ef. 8-2-05 thru 1-27-06; DOF 8-2005, f. 12-13-05, cert. ef. 1-1-06; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-665-0230
Bald Eagle Roosting Sites; Key Components; Protection Requirements; and Exceptions

(1) For bald eagle roosting sites, the resource site is the active roost trees, probable roost trees as identified by the State Forester, and all identified key components:

(a) An active roosting site is one that has been used within the past 5 years for roosting by bald eagles. No protection is required for an abandoned bald eagle roosting site.

(b) The key components associated with a bald eagle roosting site are staging trees, probable roost trees as identified by the State Forester, and a forested buffer around the roost trees. Factors to consider when identifying key components:

(A) Actual observation data when available.

(B) Roost sites frequently occur in mature forests. Roost trees are often significantly larger than the rest of the stand.

(C) Staging trees are often large, dead-top or dominant trees or snags where one or more eagles can perch and have direct access to the roosting site.

(D) The surrounding forested buffer must be adequate to maintain a suitable microclimate around the roost trees.

(E) Areas of high winds may require that additional trees be retained to protect the active roost tree(s) and identified key components from damage.

(2) The operator shall provide the following protection measures when operating within or near a bald eagle roosting site:

(a) During and after forest operations, the resource site shall be retained and protected from damage. The operation shall be designed to protect the trees from windthrow.

(b) Retain the active roost tree(s).

(c) Retain a forested buffer not less than 300 feet around the outermost active roost trees as a key component that includes probable roost trees.

(d) Retain staging trees.

(e) During the critical period of use, operations shall be designed and conducted to not disturb bald eagles using the resource site:

(A) Except as provided in paragraph (B) of this subsection, during the critical period of use, operations shall not be permitted within one-quarter (1/4) mile of the active roost trees. If the eagles have line-of-sight vision from these trees to the operation, the distance is one-half (1/2) mile.

(B) If the State Forester determines through review of the written plan that the operations will not cause the birds to flush from trees identified in paragraph (A) of this subsection, then there is no conflict and the distance restrictions in paragraph (A) of this subsection may be modified.

(C) The critical period of use for bald eagle roosting sites in the Klamath Basin is October 31 through March 31. In other areas of Oregon the critical period of use is November 15 through March 15. The specific critical period of use for individual roosting resource sites may be modified in writing by the State Forester depending upon the actual dates that bald eagles are present at the resource site and are susceptible to disturbance.

(3) Structural or temporal exceptions for the resource site are allowed if the operator is in compliance with, and has on file with the State Forester, an applicable incidental take permit issued by federal authorities under the Endangered Species Act.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.715
Hist.: FB 7-1991, f. & cert. ef. 10-30-91; FB 9-1996, f. 12-2-96, cert. ef. 1-1-97, Renumbered from 629-024-0812; DOF 6-2005(Temp), f. & cert. ef. 8-2-05 thru 1-27-06; DOF 8-2005, f. 12-13-05, cert. ef. 1-1-06; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-670-0214
Civil Penalty Administrator Discretion

(1) The civil penalty administrator shall have the discretion to combine violations for the sake of assessing reasonable penalties, under the following circumstances:

(a) Multiple citations have been issued for violations resulting from the same practice;

(b) Multiple citations have been issued for violations resulting in the same damage; or

(c) Upon a finding of the State Forester that a combination of violations is in the public interest and consistent with the policy of the Oregon Forest Practices Act, ORS 527.630.

(2) The civil penalty administrator shall have the discretion to find a penalty is not warranted for reforestation violation cases, when:

(a) The party cited for the violation was not the landowner at the time the harvesting operation reduced stocking below the minimum standards; and

(b) Planting is completed as directed in the repair order.

(3) The civil penalty administrator shall have the discretion to find a penalty is not warranted for cases where all of the following conditions exist:

(a) The violation arose inadvertently;

(b) There was little or no potential for damage;

(c) No damage resulted; and

(d) The cooperation of the operator shows there is little or no chance that the violation will be repeated.

(4) Penalties totaling less than $100 shall be suspended, pending no further violations within one year of issuance of the citation.

(5) The civil penalty administrator shall have the discretion to reduce the amount of the civil penalty when the party assessed:

(a) Agrees to the facts of the case;

(b) Accepts responsibility for the violation; and

(c) Agrees to perform mitigation on the operation unit, or within the watershed, that is equal or greater in value than the amount by which the penalty will be reduced. Examples may include, but are not limited to, any of the following restoration and enhancement activities:

(A) Reconstructing, relocating, or vacating roads that, because of their location, present a higher risk to water quality than if they had been located and designed to current forest practice rule standards;

(B) Restoring or enhancing upstream and downstream fish passage, including replacing crossing structures not designed to current forest practice rule standards;

(C) Restoring or enhancing fish habitat by placing large woody debris or other structures in or adjacent to stream channels;

(D) Retaining conifers adjacent to streams, to supplement current forest practice rule requirements, consistent with forest health considerations;

(E) Restoring or enhancing habitat for threatened and endangered species or other wildlife habitat;

(F) Restoring or enhancing the protection of salmonid production areas. Salmonid production areas include habitat identified through stream or other inventories as being important for spawning, rearing, or over-wintering;

(G) Participating in a research or monitoring program sponsored or endorsed by the Department of Forestry or the Department of Fish and Wildlife;

(H) Participating with Watershed Councils to conduct watershed assessments, develop action plans or implement restoration projects;

(I) Controlling noxious weeds or exotic species; or

(J) Implementing strategies to reduce the risk of catastrophic fire or insect or disease damage.

Stat. Auth.: ORS 527.710 & 526.016

Stats. Implemented: ORS 527.685
Hist.: DOF 7-2002, f. & cert. ef. 7-1-02; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

629-680-0020
Resource Site Defined for the Purpose of a Hearing

(1) Notwithstanding OAR 629-600-0100(61), 629-665-0110(1), 629-665-0120(1), 629-665-0220(1), 629-665-0230(1), and 629-665-0240(1), key components are not considered a part of the resource site in determining the place from which distances are measured for the purpose of requesting a hearing under ORS 527.670(4) and 527.700(3).

(2) For threatened or endangered bird species, the place from which such distances are measured is the active nest tree, roost trees, or foraging perch.

(3) For birds which use sensitive bird nesting, roosting or watering sites, the place from which such distances are measured is the specific nest tree, roosting tree or watering place.

(4) For significant wetland types identified in OAR 629-680-0310, the place from which such distances are measured is the significant wetland boundary as determined by the State Forester.

(5) For other sites protected under ORS 527.710(3)(a), the place will be defined by rule as rules are adopted to protect the sites.

Stat. Auth.: ORS 527.710
Stats. Implemented: ORS 527.715
Hist.: FB 4-1990, f. & cert. ef. 7-25-90; FB 3-1991, f. & cert. ef. 5-23-91; FB 8-1991, f. & cert. ef. 10-30-91; FB 9-1996, f. 12-2-96, cert. ef. 1-1-97, Renumbered from 629-056-0900; DOF 2-2013, f. 7-11-13, cert. ef. 9-1-13

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Department of Human Services, Aging and People with Disabilities and Developmental Disabilities
Chapter 411

Rule Caption: Support Services for Adults with Intellectual or Developmental Disabilities
Adm. Order No.: SPD 13-2013(Temp)
Filed with Sec. of State: 7-1-2013
Certified to be Effective: 7-1-13 thru 12-28-13
Notice Publication Date:
Rules Amended: 411-340-0100, 411-340-0110, 411-340-0120, 411-340-0125, 411-340-0130, 411-340-0150
Subject: The Department of Human Services (Department) is immediately amending the support services rules for adults with intellectual or developmental disabilities in OAR chapter 411, division 340 to:

Reflect new definitions applicable to Community First Choice State Plan services;

Specify the eligibility requirements to reflect changes made as a result of the Community First Choice State Plan;

Describe and coincide with the services available in the Community First Choice State Plan and Home and Community-Based Waiver amendments;

Require a functional needs assessment as part of an individual's service planning process; and

Clarify the responsibilities of support services brokerages providing case management services.
Rules Coordinator: Christina Hartman—(503) 945-6398

411-340-0100
Eligibility for Support Service Brokerage Services

(1) NON-DISCRIMINATION. Individuals determined eligible according to this rule may not be denied brokerage services or otherwise discriminated against on the basis of age, diagnostic or disability category, race, color, creed, national origin, citizenship, income, or duration of Oregon residence.

(2) ELIGIBILITY. The CDDP of an individual's county of residence may find the individual eligible for a brokerage when:

(a) The individual is an Oregon resident who has been determined eligible for developmental disability services by the CDDP; AND

(b) The individual is an adult living in the individual's own home or family home; AND

(c) At the time of initial entry to the brokerage, the individual is not enrolled in comprehensive services; AND

(d) At the time of initial entry to the brokerage, the individual is not receiving short-term services from the Department because the individual is eligible for, and at imminent risk of, civil commitment under ORS Chapter 427.215 through 427.306; AND

(e) The individual or the individual's representative has chosen to use a brokerage for assistance with design and management of personal supports.

(3) CONCURRENT SERVICES. Individuals are not eligible for service by more than one brokerage unless the concurrent service:

(a) Is necessary to affect transition from one brokerage to another;

(b) Is part of a collaborative plan between the affected brokerages; and

(c) Does not duplicate services and expenditures.

Stat. Auth.: ORS 409.050 & 410.070
Stats. Implemented: ORS 427.005, 427.007, 430.610–430.695
Hist.: MHD 9-2001(Temp), f. 8-30-01, cert. ef. 9-1-01 thru 2-27-02; MHD 5-2002, f. 2-26-02 cert. ef. 2-27-02; Renumbered from 309-041-1840, SPD 22-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 8-2008, f. 6-27-08, cert. ef. 6-29-08; SPD 8-2009, f. & cert. ef. 7-1-09; SPD 18-2011(Temp), f. & cert. ef. 7-1-11 thru 12-28-11; SPD 21-2011(Temp), f. & cert. ef. 8-31-11 thru 12-28-11; SPD 27-2011, f. & cert. ef. 12-28-11; SPD 13-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-340-0110
Standards for Support Service Brokerage Entry and Exit

(1) The brokerage must make accurate, up-to-date information about the brokerage available to individuals referred for services. This information must include:

(a) A declaration of brokerage philosophy;

(b) A brief description of the services provided by the brokerage, including typical timelines for activities;

(c) A description of processes involved in using the services, including application and referral, assessment, planning, and evaluation;

(d) A declaration of brokerage employee responsibilities as mandatory abuse reporters;

(e) A brief description of individual responsibilities for use of public funds;

(f) An explanation of individual rights, including an individual's right to:

(A) Choose a brokerage from among Department contracted brokerages in an individual's county of residence that is serving less than the total number of individuals specified in the brokerage's current contract with the Department;

(B) Choose a personal agent among those available in the selected brokerage;

(C) Select providers among those willing, available, and qualified according to OAR 411-340-0160, 411-340-0170, and 411-340-0180 to provide supports authorized through the ISP;

(D) Direct the services of providers; and

(E) Raise and resolve concerns about brokerage services, including specific rights to notification and hearing for Medicaid recipients according to OAR 411-340-0060 when services covered under Medicaid are denied, terminated, suspended, or reduced.

(g) Indication that additional information about the brokerage is available on request. The additional information must include but not be limited to:

(A) A description of the brokerage's organizational structure;

(B) A description of any contractual relationships the brokerage has in place or may establish to accomplish the brokerage functions required by rule; and

(C) A description of the relationship between the brokerage and the brokerage's Policy Oversight Group.

(2) The brokerage must make information required in OAR 411-340-0110(1) of this rule available using language, format, and presentation methods appropriate for effective communication according to individuals' needs and abilities.

(3) ENTRY INTO BROKERAGE SERVICES.

(a) To enter brokerage services:

(A) An individual must be determined by the CDDP to be eligible for brokerage services according to OAR 411-340-0100; and

(B) The individual or the individual's representative must choose to receive services from a selected brokerage.

(b) The Department may implement guidelines that govern entries when the Department has determined that such guidelines are prudent and necessary for the continued development and implementation of support services.

(c) The brokerage may not accept individuals for entry beyond the total number of individuals specified in the brokerage's current contract with the Department.

(4) EXIT FROM A BROKERAGE.

(a) An individual must exit a brokerage:

(A) At the written request of the individual or the individual's legal representative to end the service relationship;

(B) Effective July 1, 2013, if an individual requests case management services from a CDDP, the brokerage must refer the individual to the local CDDP for case management within 10 working days of the request.

(C) No fewer than 30 days after the brokerage has served written notice of intent to exit from brokerage services, when the individual either cannot be located or has not responded to repeated attempts by brokerage staff to complete ISP development or monitoring activities, and does not respond to the notice of intent to terminate;

(D) Upon entry into a comprehensive service; (b) Any individual being exited from a brokerage shall be given written notice of the intent to terminate service at least 10 days prior to the termination.

(c) Each brokerage must have policies and procedures for notifying the CDDP of an individual's county of residence when that individual plans to exit, or exits, brokerage services. Notification method, timelines, and content must be based on agreements between the brokerage and CDDP's of each county in which the brokerage provides services.

Stat. Auth.: ORS 409.050 & 410.070

Stats. Implemented: ORS 427.005, 427.007, 430.610–430.695

Hist.: MHD 9-2001(Temp), f. 8-30-01, cert. ef. 9-1-01 thru 2-27-02; MHD 5-2002, f. 2-26-02 cert. ef. 2-27-02; MHD 4-2003(Temp); f. & cert. ef. 7-1-03 thru 12-27-03; Renumbered from 309-041-1850, SPD 22-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 32-2004, f. & cert. ef. 10-25-04; SPD 8-2005, f. & cert. ef. 6-23-05; SPD 17-2006, f. 4-26-06, cert. ef. 5-1-06; SPD 8-2008, f. 6-27-08, cert. ef. 6-29-08; SPD 8-2009, f. & cert. ef. 7-1-09; SPD 21-2011(Temp), f. & cert. ef. 8-31-11 thru 12-28-11; SPD 27-2011, f. & cert. ef. 12-28-11; DVA 3-2007, f. & cert .ef. 9-25-07

411-340-0120

Support Service Brokerage Services

(1) Each brokerage must provide or arrange for the following services as required to meet individual support needs:

(a) Assistance for individuals to determine needs, plan supports in response to needs, and, for individuals whose entry into support services occurred prior to October 1, 2013 develop individualized budgets based on available resources;

(b) Assistance for individuals to find and arrange the resources to provide planned supports;

(c) Assistance with development and expansion of community resources required to meet the support needs of individuals served by the brokerage;

(d) Information, education, and technical assistance for individuals to use to make informed decisions about support needs and to direct providers;

(e) Fiscal intermediary services in the receipt and accounting of support services funds on behalf of an individual in addition to making payment to providers with the authorization of the individual;

(f) Employer-related supports; and

(g) Assistance for individuals to effectively put plans into practice, including help to monitor and improve the quality of supports as well as assess and revise plan goals.

(2) SELF-DETERMINATION. Brokerages must apply the principles of self-determination to provision of services required in OAR 411-340-0120 of this rule.

(3) PERSON-CENTERED PLANNING. A brokerage must use a person-centered planning approach to assist individuals to establish outcomes, determine needs, plan for supports, and review and redesign support strategies.

(4) HEALTH AND SAFETY ISSUES. The planning process must address basic health and safety needs and supports including but not limited to:

(a) Identification of risks, including risk of serious neglect, intimidation, and exploitation;

(b) Informed decisions by the individual or the individual's legal representative regarding the nature of supports or other steps taken to ameliorate any identified risks; and

(c) Education and support to recognize and report abuse.

(5) PERSONAL AGENT SERVICES.

(a) An individual entered into brokerage services must be assigned a personal agent for case management services.

(b) INITIAL DESIGNATION OF PERSONAL AGENT.

(A) The brokerage must designate a personal agent for individuals newly entered in support services within 10 working days from the date entry becomes known to the brokerage.

(B) In the instance of an individual transferring into a brokerage from another brokerage, the brokerage must designate a personal agent within 10 days of entry to the new brokerage.

(C) The brokerage must send a written notice that includes the name, telephone number, and location of the personal agent or brokerage to the individual and the individual's legal representative within 10 working days from the date entry becomes known to the brokerage.

(D) Prior to implementation of the initial ISP, the brokerage shall ask the individual or the individual's legal representative to identify any family and other advocates to whom the brokerage shall provide the name, telephone number, and location of the personal agent.

(c) CHANGE OF PERSONAL AGENT. Changes of personal agents initiated by the brokerage must be kept to a minimum. If the brokerage must change personal agent assignments, the brokerage must notify the individual, the individual's legal representative, and all current service providers within 10 working days of the change. The notification must be in writing and include the name, telephone number, and address of the new personal agent, if known, or of a contact person at the brokerage.

(d) If an individual loses OSIP-M eligibility, the personal agent must assist the individual in identifying why OSIP-M eligibility was lost. Whenever possible, the personal agent must assist the individual in becoming eligible for OSIP-M again. The personal agent must document efforts taken to assist the individual in becoming eligible OSIP-M eligible.

(6) PARTICIPATION IN PROTECTIVE SERVICES. The brokerage and personal agent are responsible for the delivery of protective services, in cooperation with the CDDP, through the completion of activities necessary to address immediate health and safety concerns.

(7) LEVEL OF CARE ASSESSMENT. The brokerage must assure that individuals who are eligible or become eligible for OSIP-M after entry into the brokerage receive a level of care assessment. These individuals must:

(a) Be offered the choice between home and community-based services or institutional care;

(b) Be provided a notice of fair hearing rights; and

(c) Have the level of care assessment reviewed annually or at any time there is a significant change in the criteria that qualified the individual for institutional level of care. The level of care assessment must be documented in a case note in the individual's record. The level of care assessment must be completed no more than 60 days prior to the authorization of the initial plan Individual Support Plan and the annual reauthorization.

(8) FUNCTIONAL NEEDS ASSESSMENT.

(a) The brokerage must complete a functional needs assessment at least annually. The FNAT must be completed:

(A) Within 30 days of entry into a brokerage;

(B) Within 60 days prior to the authorization of a plan renewal;

(C) For an individual whose initial or annual plan was authorized on or after October 1, 2013, within 45 days from the time the individual requests a functional needs assessment.

(b) After July 1, 2013, an individual who has not yet had an annual plan renewal may not request a FNAT unless the individual meets crisis criteria according to OAR 411-340-0125.

(9) WRITTEN PLAN REQUIRED.

(a) Unless circumstances allow exception under section (8)(c) of this section, an individual who meets the level of care and is OSIP-M eligible, must have an authorized ISP.

(A) The ISP must be written by a personal agent.

(B) The ISP must be dated within 60 days of the completion of an FNAT and at least annually thereafter.

(C)The brokerage must provide a written copy of the most current ISP to the individual and the individual's legal representative.

(b) For an initial ISP that is authorized on or after July 1, 2013, and for an annual ISP that is authorized on or after October 1, 2013, the ISP must address all the support needs identified on the FNAT. The ISP or attached documents must include:

(A) The individual's name;

(B) A description of the supports required, including the reason the support is necessary. For an initial ISP that is authorized on or after July 1, 2013, and for an annual ISP that is authorized on or after October 1, 2013, the description must be consistent with the FNAT;

(C) Projected dates of when specific supports are to begin and end;

(D) For an initial or annual ISP that is authorized prior to October 1, 2013 projected costs, with sufficient detail to support estimates;

(E) A list of personal, community, and public resources that are available to the individual and how they shall be applied to provide the required supports. Sources of support may include waivered and state plan services, state general funds, or natural supports.

(F) The providers, or when the provider is unknown or is likely to change frequently, the type of provider (i.e. independent provider, provider

organization, or general business provider), of supports to be purchased with support services funds;

(G) Schedule of ISP reviews; and

(H) Any revisions to OAR 411-340-0120(8)(a)(A) to (G) of this section that may alter:

(i) The amount of support services funds required;

(ii) The amount of support services required;

(iii) Types of support purchased with support services funds; and

(iv) The type of support provider.

(I) For individuals whose entry into support services occurred prior to October 1, 2013, and for an annual ISP that is authorized on or after October 1, 2013, the ISP must reflect any changes in support needs identified on a FNAT.

(c) The schedule of the support services ISP, developed in compliance with OAR 411-340-0120(3) of this rule after an individual enters a brokerage, may be adjusted one time for any individual entering a brokerage in certain circumstances. Such an adjustment shall interrupt any plan year in progress and establish a new plan year for the individual beginning on the date the first new ISP is authorized. Circumstances where this adjustment is permitted include:

(A) Brokerages, with the consent of the individual, may designate a new ISP start date.

(i) This adjustment may only occur one time per individual upon ISP renewal.

(ii) ISP date adjustments must be clearly documented on the ISP.

(B) Transition of individuals receiving family support services for children with intellectual or developmental disabilities regulated by OAR chapter 411, division 305, children's intensive in-home services (CIIS) regulated by OAR chapter 411, division 300, or medically fragile children (MFC) services regulated by OAR chapter 411, division 350, when those individuals are 18 years of age. The date of the individual's first new support services ISP after entry to the brokerage may be adjusted to correspond to the expiration date of the individual's Annual Plan of Care in place at the time the individual turns 18 years of age when the Annual Plan of Care, developed while the individual is still receiving family support, CIIS, or MFC services, has been authorized for implementation prior to or upon the individual's entry to the brokerage.

(C) Transition of individuals receiving other Department-paid services who are required by the Department to transition to support services. The date of the individual's first support services ISP may be adjusted to correspond to the expiration date of the individual's plan for services when the plan for services:

(i) Has been developed according to regulations governing Department-paid services the individual receives prior to transition;

(ii) Is current at the time designated by the Department for transition to support services; and

(iii) Is authorized for implementation prior to or upon the individual's entry to the brokerage.

(d) An Annual Plan must be completed for an individual who does not meet the level of care or is not eligible for OSIP-M.

(10) PROFESSIONAL OR OTHER SERVICE PLANS.

(a) A Nursing Care Plan must be attached to the ISP when support services funds are used to purchase services requiring the education and training of a licensed professional nurse.

(b) A Support Services Brokerage Plan of Care Crisis Addendum, or other document prescribed by the Department for use in these circumstances, must be attached to the ISP when an individual enrolled in a brokerage is in emergent status in a short-term, out-of-home, residential placement as part of the individual's crisis diversion services.

(11) ISP AUTHORIZATION.

(a) An initial and annual ISP must be authorized prior to implementation.

(b) A revision to the annual or initial ISP that involves the types of support purchased with support services funds must be authorized prior to implementation.

(c) A revision to the annual or initial ISP that does not involve the types of support purchased with support services funds does not require authorization. Documented verbal agreement to the revision by the individual or the individual's legal representative is required prior to implementation of the revision.

(d) An ISP is authorized when:

(A) The signature of the individual or the individual's legal representative is present on the ISP or documentation is present explaining the reason an individual who does not have a legal representative may be unable to sign the ISP.

(i) Acceptable reasons for an individual without a legal representative not to sign the ISP include physical or behavioral inability to sign the ISP.

(ii) Unavailability of the individual is not an acceptable reason for the individual or the individual's legal representative not to sign the ISP.

(iii) In the case of a revision to the initial or annual ISP that is in response to immediate, unexpected change in circumstance, and is necessary to prevent injury or harm to the individual, documented verbal agreement may substitute for a signature for no more than 10 working days.

(B) The signature of the personal agent involved in the development of, or revision to, the ISP is present on the ISP; and

(C) A designated brokerage representative has reviewed the ISP for compliance with Department rules and policy.

(12) PERIODIC REVIEW OF PLAN AND RESOURCES.

(a) The personal agent must conduct and document reviews of plans and resources with the individual and the individual's legal representative.

(b) At least annually as part of preparation for a new ISP, the personal agent must:

(A) Evaluate progress toward achieving the purposes of the ISP, assessing and revising goals as needed;

(B) Note effectiveness of the use of support services funds based on personal agent observation as well as individual satisfaction;

(C) Determine whether changing needs or availability of other resources has altered the need for continued use of support services funds to purchase supports; and

(D) Record final support services fund costs.

(13) TRANSITION TO ANOTHER BROKERAGE. At the request of an individual enrolled in brokerage services who has selected another brokerage, the brokerage must collaborate with the receiving brokerage and the CDDP of the individual's county of residence to transition support services.

(a) If the Department has designated and contracted funds solely for the support of the transitioning individual, the brokerage must notify the Department to consider transfer of the funds for the individual to the receiving brokerage.

(b) The ISP in place at the time of request for transfer may remain in effect 90 days after entry to the new brokerage while a new ISP is negotiated and authorized.

Stat. Auth.: ORS 409.050 & 410.070

Stats. Implemented: ORS 427.005, 427.007, & 430.610 - 430.695

Hist.: MHD 9-2001(Temp), f. 8-30-01, cert. ef. 9-1-01 thru 2-27-02; MHD 5-2002, f. 2-26-02 cert. ef. 2-27-02; MHD 4-2003(Temp); f. & cert. ef. 7-1-03 thru 12-27-03; Renumbered from 309-041-1860, SPD 22-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 8-2005, f. & cert. ef. 6-23-05; SPD 17-2006, f. 4-26-06, cert. ef. 5-1-06; SPD 8-2008, f. 6-27-08, cert. ef. 6-29-08; SPD 8-2009, f. & cert. ef. 7-1-09; SPD 25-2010(Temp), f. & cert. ef. 11-17-10 thru 5-16-11; SPD 10-2011, f. & cert. ef. 5-5-11; SPD 27-2011, f. & cert. ef. 12-28-11; SPD 13-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-340-0125

Crisis Supports in Support Services

(1) The brokerage must, in conjunction with its Regional Crisis Diversion Program, attempt to provide supports that mediate a crisis risk factor for adults who are:

(a) Entered in support services; and

(b) Determined to be in crisis as described in OAR 411-340-0125(2) of this rule.

(2) CRISIS DETERMINATION.

(a) An individual enrolled in support services is eligible for crisis diversion services when:

(A) A brokerage has referred an individual to the Regional Crisis Diversion Program because the brokerage has determined that one or more of the following crisis risk factors, not primarily related to a significant mental or emotional disorder or substance abuse, are present and for which no appropriate alternative resources are available:

(i) An individual is not receiving necessary supports to address life-threatening safety skill deficits;

(ii) An individual is not receiving necessary supports to address life-threatening issues resulting from behavioral or medical conditions;

(iii) An individual currently engages in self-injurious behavior serious enough to cause injury that requires professional medical attention;

(iv) An individual undergoes, or is at imminent risk of undergoing, loss of caregiver due to caregiver inability to provide supports;

(v) An individual experiences a loss of home due to a protective service action; or

(vi) An individual is not receiving the necessary supports to address significant safety risks to others, including but not limited to:

(I) A pattern of physical aggression serious enough to cause injury;

(II) Fire-setting behaviors; or

(III) Sexually aggressive behaviors or a pattern of sexually inappropriate behaviors.

(B) The Regional Crisis Diversion Program has determined crisis eligibility according to OAR 411-320-0160.

(C) The individual's ISP has been revised to address the identified crisis risk factors and the revisions:

(i) May resolve the crisis; and

(ii) May not contribute to new or additional crisis risk factors.

(b) On or after October 1, 2013, an FNAT must be completed for any individual determined to be in crisis as described in this section of the rule.

(3) CRISIS SUPPORTS.

(a) An ISP for an individual in emergent status may authorize short-term, out-of-home, residential placement. Residential placement does not exit an individual from support services.

(b) The individual's personal agent must:

(A) Participate with the Regional Crisis Diversion Program staff in efforts to stabilize supports and return costs to the individual's benefit level;

(B) Assist with the identification of qualified providers who may be paid in whole or in part using crisis diversion funding except in the case of short-term, out-of-home, residential placements with a licensed or certified provider;

(C) Complete and coordinate the Support Services Brokerage Plan of Care Crisis Addendum when an individual in emergent status requires a short-term, out-of-home, residential placement; and

(D) Monitor the delivery of supports provided, including those provided through crisis funding.

(i) Monitoring is done through contact with the individual, any service providers, and the individual's family.

(ii) Monitoring is done to collect information regarding supports provided and progress toward outcomes that are identified as necessary to resolve the crisis.

(iii) The personal agent must document the information described in OAR 411-340-0125(3)(b)(D)(ii) of this section in the individual's case file and report to the Regional Crisis Diversion Program or CDDP as required.

(E) For an individual accessing support services who is not OSIP-M eligible, the personal agent must assist the individual in identifying why OSIP-M eligibility was lost. Whenever possible, the personal agent must assist the individual in becoming eligible for OSIP-M again. The personal agent must document efforts taken to assist the individual in becoming eligible OSIP-M eligible.

(c) Support services provided during emergent status are subject to all requirements of this rule.

(d) All supports authorized in an ISP continue during the crisis unless prohibited by other rule, policy, or the supports contribute to new or additional crisis risk factors.

(4) TRANSITION TO COMPREHENSIVE SERVICES. When an individual eligible for crisis supports may have long-term support needs that may not be met through support services:

(a) The brokerage must immediately notify the CDDP of the individual's county of residence;

(b) The brokerage must coordinate with the CDDP and the Regional Crisis Diversion Program to facilitate a timely exit from support services and entry into appropriate, alternative services; and

(c) The brokerage must assure that information required for a potential provider of comprehensive services is available as needed for a referral to be made.

Stat. Auth.: ORS 409.050 & 410.070

Stats. Implemented: ORS 427.005, 427.007, & 430.610 – 430.695

Hist.: SPD 27-2011, f. & cert. ef. 12-28-11; SPD 13-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-340-0130

Using Support Services Funds to Purchase Supports

(1) A brokerage may use support services funds to assist individuals to purchase supports in accordance with an ISP when:

(a) Supports are necessary for an individual to live in the individual's own home or in the family home;

(b) For an initial ISP that is authorized on or after July 1, 2013, and for an annual ISP that is authorized on or after October 1, 2013 an FNAT has determined the supports to be necessary;

(c) An enrolled individual meets the criteria for level of care;

(d) An enrolled individual is eligible for OSIP-M;

(e) Cost-effective arrangements for obtaining the required supports, applying public, private, formal, and informal resources available to the eligible individual are specified in the ISP;

(A) Support services funds are not intended to replace the resources available to an individual from their natural support system. Support services funds may be authorized only when the natural support system is unavailable, insufficient, or inadequate to meet the needs of the individual.

(B) Support services funds are not available when an individual's support needs may be met by alternative resources. Support services funds may be authorized only when alternative resources are unavailable, insufficient, or inadequate to meet the needs of the individual.

(f) For individuals whose entry into support services occurred prior to October 1, 2013, or whose annual ISP is authorized prior to October 1, 2013, the ISP projects the amount of support services funds, if any, that may be required to purchase the remainder of necessary supports ; and

(g) The ISP has been authorized for implementation.

(2) A brokerage may use support services funds to assist individuals that do not meet the criteria in subsection (c) or (d) in the following circumstances:

(a) An individual meets the crisis criteria listed in 411-340-0125; or

(b) Up to the individual's 18th birthday the individual was enrolled in the Children's Intensive In-home Services (CIIS) Program as described in OAR chapter 411, division 300 or Long Term Supports as described in OAR chapter 411, division 308.

(3) The individual may no longer access support services after 10 days when an individual is eligible for support services based on section (1)(f); and

(a) The individual does not apply for a disability determination and OSIP-M within 10 business days of the individual's 18th birthday; OR

(b) The Social Security Administration or the Department's Presumptive Medicaid Disability Determination Team finds that an individual does not have a qualifying disability; OR

(c) The individual is determined by the State of Oregon to be ineligible for OSIP-M.

(4) Goods and services purchased with support services funds on behalf of individuals are provided only as social benefits.

(5) LIMITS OF FINANCIAL ASSISTANCE. For individuals whose entry into support services occurred prior to October 1, 2013, the use of support services funds to purchase individual supports in any plan year is limited to the individual's annual benefit level.

(a) Individuals must have access throughout the plan year to the total annual amount of support services for which they are eligible that are determined to be necessary to implement an authorized ISP, even if there is a delay in implementation of the ISP, unless otherwise agreed to in writing by the individual or the individual's legal representative.

(b) The Department may require that annual benefit level amounts be calculated and applied on a monthly basis when an individual's eligibility for Medicaid changes during a plan year, an individual's benefit level changes, or when an individual's ISP is developed and written to be in effect for less than 12 months.

(A) Except in the case of an individual whose benefit level changes as the result of a change in eligibility for the Support Services Waiver, when an individual's benefit level changes, the monthly benefit level shall be 1/12 of the annual benefit level for which the individual would be eligible should the change in benefit level remain in effect for 12 calendar months. The monthly benefit level shall be applied each month for the remainder of the plan year in which the individual's change in benefit level occurred, from the date the change occurred.

(B) In the case of an individual with an ISP developed for a partial plan year, the monthly benefit level shall be 1/12 of the annual benefit level for which the individual would be eligible should the individual's ISP be in effect for 12 calendar months. The monthly benefit level shall be applied each month during which the ISP of less than 12 months' duration is in effect.

(c) Estimates of the cost for each unique support service purchased with support services funds must be based on the Department's Support Services Rate Guidelines for costs of frequently used services.

(A) Notwithstanding the Department's Support Services Rate Guidelines, final costs for any support service purchased with support services funds may not exceed local usual and customary charges for these services as evidenced by the brokerage's own documentation.

(B) The brokerage must establish a process for review and approval of all cost estimates exceeding the Department's Support Services Rate Guidelines and must monitor the authorized ISP involved for continued cost effectiveness.

(6) EXCEPTIONS TO BASIC BENEFIT FINANCIAL LIMITS.

(a) Exceptions to the basic benefit annual support services fund limits do not apply to individuals whose entry into support services occurs on

or after October 1, 2013 or whose annual ISP is authorized on or after October 1, 2013.

(b) Exceptions to the basic benefit annual support services fund limit for individuals whose entry into support services occurs prior to October 1, 2013 or whose annual ISP is authorized prior to October 1, 2013 may be only as follows:

(A) Individuals with extraordinary long-term need as demonstrated by a score of 60 or greater on the Basic Supplement Criteria Inventory (Form DHS 0203) may have access to a basic supplement in order to purchase necessary supports.

(B) For Medicaid recipients choosing services under the Support Services Waiver, the basic supplement must result in a plan year cost that is not greater than the individual cost limit.

(C) The brokerage director, or a designee from brokerage management and administration, must administer the Basic Supplement Criteria Inventory only after receiving Department-approved training. The brokerage director or designee must score basic supplement criteria according to written and verbal instruction received from the Department.

(D) The trained brokerage director or a designee from a brokerage's management or administration must administer the Basic Supplement Criteria Inventory within 30 calendar days of the documented request of the individual or the individual's legal representative.

(E) The brokerage director or designee must send written notice of findings regarding eligibility for a basic supplement to the individual and the individual's legal representative within 45 calendar days of the documented request for a basic supplement. This written notice must include:

(i) An offer for the individual and the individual's legal representative to discuss the findings in person with the director and with the individual's personal agent in attendance if desired;

(ii) A notice of the complaint process under OAR 411-340-0060; and

(iii) A notice of planned action.

(F) Annual ISP reviews for recipients of the basic supplement must include a review of circumstances and resources to confirm continued need according to the instructions included with the Basic Supplement Criteria Inventory.

(G) The basic supplement must be used to address the conditions and caregiver circumstances identified in the Basic Supplement Criteria Inventory as contributing to the extraordinary long-term need.

(c) An individual in emergent status may receive crisis diversion services that may cause an individual's benefit level to be exceeded.

(A) Use of crisis diversion services and length of emergent status may be authorized only by the CDDP of the individual's county of residence, or the Regional Crisis Diversion Program responsible for the individual's county of residence, depending on the source of the funds for crisis diversion services.

(B) Funds associated with crisis diversion services may be used to pay the difference in cost between the authorized ISP and the supports authorized by either the CDDP of the individual's county of residence or the Regional Crisis Diversion Program responsible for crisis diversion services in the individual's county of residence, depending on the source of crisis diversion services funds required to meet the short-term need.

(C) Although costs for crisis diversion services may bring the individual's total plan year cost temporarily above the individual cost limit, the individual's costs may not exceed the cost of the state's current ICF/IDD daily cost per individual. Plan year expenses at or above the individual cost limit do not make the individual eligible for comprehensive services.

(D) Individuals placed in emergent status due to receiving crisis diversion services authorized and provided according to OAR 411-320-0160 may remain enrolled in, and receive support services from, the brokerage while both crisis diversion services and support services are required to stabilize and maintain the individual at home or in the family home..

(d) Individuals whose source of support funds are, in whole or in part, an individual-specific redirection of funds through a Department contract from a Department-regulated residential, work, or day habilitation service to support services funds, or to comprehensive in-home support funds regulated by OAR chapter 411, division 330 prior to entry to a brokerage, may have access to the amount specified in the Department contract as available for the individual's use. This provision is only applicable when each transition is separate and specific to the individual and the services being converted are not subject to statewide service transitions.

(A) Individual plan year costs must always be less than the individual cost limit; and

(B) The brokerage must review the need for supports and their cost-effectiveness with the individual and the individual's legal representative at least annually and must make budget reductions when allowed by the ISP.

(e) Individuals whose support funds were specifically assigned through a Department contract to self-directed support services prior to the date designated by the Department for transfer of the individual from self-directed support services to a brokerage may have access to the amount specified in the Department contract as available for the individual's use.

(A) Individual plan year costs must always be less than the individual cost limit; and

(B) The brokerage must review the need for supports and their cost-effectiveness with the individual and the individual's legal representative at least annually and must make budget reductions when allowed by the ISP.

(f) Individuals transferring from the Department's Home and Community-Based Waiver Services for the Aged and Adults with Physical Disabilities who have been determined ineligible for those waiver service funds in accordance with OAR 411-015-0015(4)(c), shall have limited access to support services funds as described in these rules. The amount of support services funds available shall be equal to the Department's previous service costs for the individual for no more than 365 calendar days. The 365 calendar days begins the date the individual starts receiving support services exclusively through a brokerage.

(g) For Medicaid recipients eligible for and choosing services under the Support Services Waiver, individuals may have access to a basic supplement for ADLs to purchase needed support services under the following conditions:

(A) The individual must have additional assistance needs with ADLs after development of their ISP within the basic benefit, extraordinary long-term need fund limit, or other exceptions provided in this rule. ADLs include:

(i) Basic personal hygiene — providing or assisting an individual with such needs as bathing (tub, bed bath, shower), washing hair, grooming, shaving, nail care, foot care, dressing, skin care, mouth care, and oral hygiene;

(ii) Toileting, bowel, and bladder care — assisting to and from bathroom, on and off toilet, commode, bedpan, urinal, or other assistive device used for toileting, changing incontinence supplies, following a toileting schedule, cleansing the individual or adjusting clothing related to toileting, emptying catheter drainage bag or assistive device, ostomy care, or bowel care;

(iii) Mobility, transfers, and repositioning — assisting the individual with ambulation or transfers with or without assistive devices, turning the individual or adjusting padding for physical comfort or pressure relief, or encouraging or assisting with range-of-motion exercises;

(iv) Nutrition — preparing meals and special diets, assisting with adequate fluid intake or adequate nutrition, assisting with food intake (feeding), monitoring to prevent choking or aspiration, assisting with special utensils, cutting food, and placing food, dishes, and utensils within reach for eating;

(v) Medication and oxygen management — assisting with ordering, organizing, and administering oxygen or prescribed medications (including pills, drops, ointments, creams, injections, inhalers, and suppositories), monitoring for choking while taking medications, assisting with the administration of oxygen, maintaining clean oxygen equipment, and monitoring for adequate oxygen supply; and

(vi) Delegated nursing tasks.

(B) Assistance means the individual requires help from another person with ADLs. Assistance may include cueing, monitoring, reassurance, redirection, set-up, hands-on, or standby assistance. Assistance may also require verbal reminding to complete one of the tasks described in OAR 411-340-0130(4)(f)(A) of this section.

(i) "Cueing" means giving verbal or visual clues during the activity to help the individual complete activities without hands-on assistance.

(ii) "Hands-on" means a provider physically performs all or parts of an activity because the individual is unable to do so.

(iii) "Monitoring" means a provider observes the individual to determine if intervention is needed.

(iv) "Reassurance" means to offer encouragement and support.

(v) "Redirection" means to divert the individual to another more appropriate activity.

(vi) "Set-up" means getting personal effects, supplies, or equipment ready so that an individual may perform an activity.

(vii) "Stand-by" means a provider is at the side of an individual ready to step in and take over the task should the individual be unable to complete the task independently.

(C) The supplement for ADLs must be used to meet identified support needs related to ADLs. The supplement for ADLs may also be used for the following services if they are incidental to the provision of ADLs, essential for the health and welfare of the individual, and provided solely for the individual receiving support services:

(i) Housekeeping tasks necessary to maintain the eligible individual in a healthy and safe environment, including cleaning surfaces and floors, making the individual's bed, cleaning dishes, taking out the garbage, dusting, and gathering and washing soiled clothing and linens. Only the housekeeping activities related to the eligible individual's needs may be considered in housekeeping;

(ii) Arranging for necessary medical appointments including help scheduling appointments and arranging medical transportation services, assistance with mobility, and transfers or cognition in getting to and from appointments;

(iii) Observation of an individual's status and reporting of significant changes to physicians, health care professionals, or other appropriate persons;

(iv) First aid and handling emergencies, including responding to medical incidents related to conditions such as seizures, spasms, or uncontrollable movements where assistance is needed by another person, or responding to an individual's call for help during an emergent situation or for unscheduled needs requiring immediate response; and

(v) Cognitive assistance or emotional support provided to an individual by another person due to intellectual or developmental disability. This support includes helping the individual cope with change and assisting the individual with decision-making, reassurance, orientation, memory, or other cognitive symptoms.

(D) The supplement for ADL support may not be used for any of the following services:

(i) Shopping;

(ii) Transportation;

(iii) Money management;

(iv) Mileage reimbursement;

(v) Social companionship; or

(vi) Respite.

(E) Activities and goals related to the provision of ADL services must be sufficiently documented in the individual's ISP.

(F) Planned expenses must be based upon the least costly means of providing adequate services and must only be to the extent necessary to meet the documented ADL needs.

(G) The supplement for ADLs may not cause the cost per any plan year to exceed the individual cost limit. There is an exception for individuals receiving both support services under these rules who had a benefit level at the individual cost limit and state plan personal care services under OAR chapter 411, division 034, as of June 30, 2005. These individuals may continue to access the basic supplement and the supplement for ADLs until the individual terminates their receipt of support services or becomes ineligible for one of the supplements. The combined basic benefit, the basic supplement, and supplement for ADLs must remain above the individual cost limit to remain eligible for this exception.

(H) For Medicaid recipients receiving state plan personal care services under OAR chapter 411, division 034 entering support services after June 30, 2005, the Medicaid Personal Care Assessment (Form SDS 0531A) shall serve as the individual's authorized ISP for a period not to exceed 90 days.

(I) The supplemental ADL services are not intended to replace the resources available to an individual receiving support services under these rules from their natural support system of relatives, friends, neighbors, or other available sources of support.

(7) AMOUNT, METHOD, AND SCHEDULE OF PAYMENT.

(a) The brokerage must disburse, or arrange for disbursement of, support services funds to qualified providers on behalf of individuals in the amount required to implement an authorized ISP. The brokerage is specifically prohibited from reimbursement of individuals or individuals' families for expenses related to services and from advancing funds to individuals or individuals' families to obtain services.

(b) The method and schedule of payment must be specified in written agreements between the brokerage and the individual or the individual's legal representative.

(8) TYPES OF SUPPORTS PURCHASED PRIOR TO JULY 1, 2013. For ISPs authorized for implementation prior to July 1, 2013, supports eligible for purchase with support services funds are:

(a) Chore services. Chore services may be provided only in situations where no one else in the household is capable of either performing or paying for the services and no other relative, caregiver, landlord, community, volunteer agency, or third-party payer is capable of or responsible for providing these services;

(b) Community living and inclusion supports;

(c) Environmental accessibility adaptation;

(d) Family training;

(A) Family training must be provided:

(i) By licensed psychologists, medical professionals, clinical social workers, or counselors as described in OAR 411-340-0160(9); or

(ii) In organized conferences and workshops that are limited to topics related to the individual's intellectual or developmental disability, identified support needs, or specialized medical or habilitative support needs.

(B) Family training may not be provided to paid caregivers.

(e) Homemaker services. Homemaker services may be provided only when the person regularly responsible for general housekeeping activities as well as caring for an individual in the home is temporarily absent, temporarily unable to manage the home as well as care for self or the individual in the home, or needs to devote additional time to caring for the individual;

(f) Occupational therapy services;

(g) Personal emergency response systems;

(h) Physical therapy services;

(i) Respite;

(A) Respite may be provided in the individual's or respite provider's home, a foster home, a group home, a licensed day care center, or a community care facility that is not a private residence.

(B) Respite includes two types of care, neither of which may be characterized as eight-hours-a-day, five-days-a-week services or provided to allow caregivers to attend school or work.

(i) Temporary respite must be provided on less than a 24-hour basis.

(ii) Twenty-four hour overnight care must be provided in segments of 24-hour units that may be sequential but may not exceed 14 consecutive days without permission from the Department.

(j) Special diets. Special diets may not provide or replace the nutritional equivalent of meals and snacks normally required regardless of intellectual or developmental disability.

(k) Specialized medical equipment and supplies as well as the following provisions:

(A) When specialized medical equipment and supplies are primarily and customarily used to serve a medical purpose, the purchase, rental, or repair of specialized medical equipment and supplies with support services funds must be limited to the types of equipment and supplies permitted under the State Medicaid Plan and specifically those that are not excluded under OAR 410-122-0080.

(B) Support services funds may be used to purchase more of an item than the number allowed under the State Medicaid Plan after the limits specified in the State Medicaid Plan have been reached, requests for purchases have been denied by the State Medicaid Plan or private insurance, and the denial has been upheld in an applicable hearing or private insurance benefit appeals process.

(C) Devices, aids, controls, supplies, or appliances primarily and customarily used to enable an individual to increase the individual's abilities to perform ADLs or to perceive, control, or communicate with the environment in which the individual lives, may be purchased with support services funds when the individual's intellectual or developmental disability otherwise prevents or limits the individual's independence in these areas. Equipment and supplies that may be purchased for this purpose must be of direct benefit to the individual and include:

(i) Adaptive equipment for eating, (i.e., utensils, trays, cups, bowls that are specially designed to assist an individual to feed him or herself);

(ii) Positioning devices;

(iii) Specially designed clothes to meet the unique needs of the individual, (e.g., clothes designed to prevent access by the individual to the stoma, etc.);

(iv) Assistive technology items;

(v) Computer software used by the individual to express needs, control supports, plan, and budget supports;

(vi) Augmentative communication devices;

(vii) Environmental adaptations to control lights, heat, stove, etc.; or

(viii) Sensory stimulation equipment and supplies that help an individual calm, provide appropriate activity, or safely channel an obsession (e.g., vestibular swing, weighted blanket, tactile supplies like creams and lotions);

(l) Specialized supports;

(m) Speech and language therapy services;

(n) Supported employment; and

(o) Transportation.

(9) TYPES OF SUPPORTS PURCHASED ON OR AFTER JULY 1, 2013. For an initial or annual ISP that is authorized after July 1, 2013, supports eligible for purchase with support services funds are:

(a) Community First Choice state plan services:

(A) Community nursing services as described in section (10) of this rule;

(B) Chore services as described in section (11) of this rule;

(C) Personal care as described in section (12) of this rule;

(D) Skills training as described in section (13) of this rule;

(E) Transportation as described in section (14) of this rule;

(F) Specialized medical equipment and supplies as described in section (15) of this rule;

(G) Respite as described in section (16) of this rule;

(H) Behavior support services as described in section (17) of this rule;

(I) Environmental accessibility adaptations as described in section (18) of this rule; and

(J) Transition costs as described in section (19) of this rule.

(b) Home and Community Based Waiver Services:

(A) Alternatives to employment — habilitation as described in section (20) of this rule;

(B) Pre-vocational services as described in section (21) of this rule;

(C) Supported employment as described in section (22) of this rule;

(D) Family training as described in section (23) of this rule;

(E) Occupational therapy as described in section (24) of this rule;

(F) Physical therapy as described in section (25) of this rule; and

(G) Speech, hearing, and language services as described in section (26) of this rule.

(10) COMMUNITY NURSING SERVICES. Community nursing services includes:

(a) Evaluation and identification of supports that minimize health risks while promoting an individual's autonomy and self-management of healthcare;

(b) Medication reviews;

(c) Collateral contact with a services coordinator regarding an individual's community health status to assist in monitoring safety and well-being and to address needed changes to the person-centered Individual Support Plan; and

(d) Delegation of nursing tasks to an individual's provider so the provider may safely perform health related tasks.

(11) CHORE SERVICES. Chore services may be provided only in situations where no one else in the home is capable of either performing or paying for the services and no other relative, caregiver, landlord, community, volunteer. agency, or third-party payer is capable of, or responsible for, providing these services;

(12) PERSONAL CARE SERVICES (ADL/IADL).

(a) Personal care services include but are not limited to:

(A) Basic personal hygiene — providing or assisting an individual with such needs as bathing (tub, bed, bath, shower), washing hair, grooming, shaving, nail care, foot care, dressing, skin care, mouth care, and oral hygiene;

(B) Toileting, bowel, and bladder care — assisting an individual to and from bathroom, on and off toilet, commode, bedpan, urinal, or other assistive device used for toileting, changing incontinence supplies, following a toileting schedule, cleansing an individual or adjusting clothing related to toileting, emptying catheter drainage bag or assistive device, ostomy care, or bowel care;

(C) Mobility, transfers, and repositioning — assisting an individual with ambulation or transfers with or without assistive devices, turning the individual or adjusting padding for physical comfort or pressure relief, or encouraging or assisting with range-of-motion exercises;

(D) Nutrition — preparing meals and special diets, assisting an individual with adequate fluid intake or adequate nutrition, assisting with food intake (feeding), monitoring to prevent choking or aspiration, assisting with special utensils, cutting food, and placing food, dishes, and utensils within reach for eating;

(E) Medication and oxygen management — assisting with ordering, organizing, and administering oxygen or prescribed medications (including pills, drops, ointments, creams, injections, inhalers, and suppositories), monitoring an individual for choking while taking medications, assisting with the administration of oxygen, maintaining clean oxygen equipment, and monitoring for adequate oxygen supply;

(F) Delegated nursing tasks;

(G) Housekeeping — tasks necessary to maintain an individual in a healthy and safe environment, including cleaning surfaces and floors, making the individual's bed, cleaning dishes, taking out the garbage, dusting, and gathering and washing soiled clothing and linens.

(H) Arranging for necessary medical appointments including help scheduling appointments and arranging medical transportation services, assistance with mobility, and transfers or cognition in getting to and from appointments;

(I) Observation of an individual's status and reporting of significant changes to physicians, health care professionals, or other appropriate persons;

(J) First aid and handling emergencies, including responding to medical incidents related to conditions such as seizures, spasms, or uncontrollable movements where assistance is needed by another person, or responding to an individual's call for help during an emergent situation or for unscheduled needs requiring immediate response; and

(K) Cognitive assistance or emotional support provided to an individual by another person due to developmental disability. This support includes helping the individual cope with change and assisting the individual with decision-making, reassurance, orientation, memory, or other cognitive symptoms.

(b) Personal care assistance means an individual requires help from another person with ADLs. Assistance may include cueing, monitoring, reassurance, redirection, set-up, hands-on, or standby assistance. Assistance may also require verbal reminding to complete one of the tasks described in subsection (b) of this section.

(A) "Cueing" means giving verbal or visual clues during an activity to help an individual complete the activity without hands-on assistance.

(B) "Hands-on" means a provider physically performs all or parts of an activity because an individual is unable to do so.

(C) "Monitoring" means a provider observes an individual to determine if intervention is needed.

(D) "Reassurance" means to offer an individual encouragement and support.

(E) "Redirection" means to divert an individual to another more appropriate activity.

(F) "Set-up" means getting personal effects, supplies, or equipment ready so that an individual may perform an activity.

(G) "Stand-by" means a provider is at the side of an individual ready to step in and take over the task should the individual be unable to complete the task independently.

(13) SKILLS TRAINING. Skills training are specifically tied to the FNAT and IHS Plan and are a means to increase independence, preserve functioning, and reduce dependency of an individual.

(14) TRANSPORTATION.

(a) Transportation services include but are not limited to:

(A) Transportation provided by common carriers, taxicab, or bus in accordance with standards established for these entities;

(B) Reimbursement on a per-mile basis for transporting an individual in a rural area into the nearest town once a week for shopping and recreational opportunities;

(C) Assistance with the purchase of a bus pass; and

(D) Reimbursement of operational expenses of agency or staff vehicles used for transporting individuals not to exceed established rates.

(b) Transportation services do not include medical transportation, purchase of individual or family vehicles, routine vehicle maintenance and repair, ambulance services, payment to the spouse of an individual receiving IHS services, and costs for transporting a person other than the individual.

(15) SPECIALIZED EQUIPMENT AND SUPPLIES. When specialized equipment and supplies are primarily and customarily used to serve a medical purpose, the purchase, rental, or repair of specialized equipment and supplies with IHS funds must be limited to the types of equipment and supplies that are not excluded under OAR 410-122-0080.

(a) Specialized equipment and supplies may include devices, aids, controls, supplies, or appliances primarily and customarily used to enable an individual to increase the individual's abilities to perform and support activities of daily living or to perceive, control, or communicate with the environment in which the individual lives.

(b) Specialized equipment and supplies may be purchased with IHS funds when an individual's intellectual or developmental disability otherwise prevents or limits the individual's independence in the areas described in section (5) of this rule

(c) Specialized equipment and supplies that may be purchased for the purpose described in subsection (b) of this section must be of direct benefit to the individual and include:

(A) Supplies needed to assist with incontinence care such as gloves, pads, wipes, or incontinence garments;

(B) Electronic devices to secure assistance in an emergency in the community and other reminders such as medication minders and alert systems for ADL or IADL supports, or mobile electronic devices;

(C) Assistive technology to provide additional security and replace the need for direct interventions to allow self direction of care and maximize independence such as motion/sound sensors, two-way communication systems, automatic faucets and soap dispensers, incontinent and fall sensors, or other electronic backup systems;

(i) Limit of $5000 per year without Department approval.

(ii) Any single device or assistance costing more than $500 in a plan year must be approved by the Department.

(D) Assistive devices. Examples include durable medical equipment, mechanical apparatus, electrical appliance or information technology device to assist and enhance an individual's independence in performing ADL/IADLs, not covered by other Medicaid programs.

(i) Limit of $5000 per year without Department approval.

(ii) Any single device or assistance costing more than $500 must be approved by the department.

(16) RESPITE.

(a) Respite may be provided in an individual's or respite provider's home, a foster home, a group home, a licensed day care center, or a community care facility that is not a private residence.

(b) Respite includes two types of care, neither of which may be characterized as eight-hours-a-day, five-days-a-week services or provided to allow an individual's provider to attend school or work.

(c) Temporary respite must be provided on less than a 24-hour basis.

(d) Twenty-four hour overnight services must be provided in segments of 24-hour units that may be sequential but may not exceed 14 consecutive days without permission from the Department.

(17) BEHAVIOR SUPPORT SERVICES.

(a) Behavior support services consist of:

(A) Assessment of an individual or the needs of the individual's family and the environment;

(B) Development of positive behavior support strategies including a Behavior Support Plan if needed;

(C) Implementation of a positive Behavior Support Plan with the provider or family; and

(D) Revision and monitoring of the plan as needed.

(b) Behavior support services may include:

(A) Training, modeling, and mentoring the family;

(B) Development of visual communication systems as behavior support strategies; and

(C) Communicating as authorized by the individual or their legal representative with school, medical, or other professionals about the strategies and outcomes of the Behavior Support Plan.

(c) Behavior support services does not include:

(A) Mental health therapy or counseling;

(B) Health or mental health plan coverage;

(C) Educational services, including, but not limited to, consultation and training for classroom staff;

(D) Adaptations to meet needs of the individual at school; or

(E) Assessment in the school setting.

(18) ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS.

(a) Environmental accessibility adaptations include but are not limited to:

(A) An environmental modification consultation to determine the appropriate type of adaptation;

(B) Installation of shatter-proof windows;

(C) Hardening of walls or doors;

(D) Specialized, hardened, waterproof, or padded flooring;

(E) An alarm system for doors or windows;

(F) Protective covering for smoke detectors, light fixtures, and appliances;

(G) Sound and visual monitoring systems;

(H) Fencing;

(I) Installation of ramps, grab-bars, and electric door openers;

(J) Adaptation of kitchen cabinets and sinks;

(K) Widening of doorways;

(L) Handrails;

(M) Modification of bathroom facilities;

(N) Individual room air conditioners for an individual whose temperature sensitivity issues create behaviors or medical conditions that put the individual or others at risk;

(O) Installation of non-skid surfaces;

(P) Overhead track systems to assist with lifting or transferring;

(Q) Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the individual;

(R) Modifications for the primary vehicle used by the individual that are necessary to meet the unique needs of the individual (lift or interior alterations such as seats, head, and leg rests; and belts, special safety harnesses, or other unique modifications to keep the individual safe in the vehicle); and

(S) Adaptations to control lights, heat, stove, etc.

(b) Environmental accessibility adaptations exclude:

(A) Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, and central air conditioning; and

(B) Adaptations that add to the total square footage of the home,

(c) Environmental modifications are limited to $5,000 per modification. A services coordinator may request approval for additional expenditures through the Department's prior to expenditure. Approval is based on the individual's need and goals and the Department's determination of appropriateness and cost-effectiveness.

(d) Environmental modifications must be tied to supporting activities of daily living, instrumental activities of daily living, and health-related tasks as identified in the IHS Plan.

(e) Modifications over $500 must be completed by a state licensed contractor. Any modification requiring a permit must be inspected and be certified as in compliance with local codes by a local inspector. Certification of compliance must be filed in the provider's file prior to payment.

(f) Environmental modifications must be made within the existing square footage of the home, except for external ramps, and may not add to the square footage of the home.

(g) Payment to the contractor is to be withheld until the work meets specifications.

(19) TRANSITION COSTS.

(a) Transition costs are limited to individuals transitioning from a nursing facility, ICF/IDD, or acute care hospital to a home or community-based setting where the individual resides.

(b) Services are based on an individual's assessed need, determined during the person-centered service planning process and must support the desires and goals of the individual receiving services and supports. Final approval for expenditures must be through the Department prior to expenditure. Approval is based on the individual's need and the Department's determination of appropriateness and cost-effectiveness.

(c) Financial assistance is limited to:

(A) Moving and move-in costs including movers, cleaning and security deposits, payment for background/credit check (related to housing), initial deposits for heating, lighting, and phone;

(B) Payment of previous utility bills that may prevent the individual from receiving utility services and basic household furnishings (i.e. bed); and

(C) Other items necessary to re-establish a home.

(d) Transition costs are provided no more than twice annually

(e) Basic household furnishings and other items are limited to one time per year.

(20) ALTERNATIVES TO EMPLOYMENT — HABILITATION is assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that takes place in a non-residential setting, separate from the home in which an individual with an intellectual or developmental disability resides.

(21) PRE-VOCATIONAL SERVICES. The IHS Plan must reflect that prevocational services are directed to habilitative rather than explicit employment objectives.

(22) SUPPORTED EMPLOYMENT SERVICES. Supported employment services assist an individual to choose, get, and keep a paid job in an integrated community business setting.

(a) Supported employment services includes job development, training, and on-going supervision to obtain paid employment.

(b) Training may focus on the individual and the individual's coworkers without disabilities capable of providing natural support.

(c) Supported employment services must not replace services available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

(d) Supported employment services under this rule may not replace or duplicate services that the individual currently receives through the Department-contracted employment and alternative to employment services governed by OAR chapter 411, division 345.

(23) FAMILY TRAINING. Family training services are training and counseling services provided to the family of an individual to increase their capabilities to care for, support, and maintain the individual in the home.

(a) Family training services include but are not limited to:

(A) Instruction about treatment regimens and use of equipment specified in the IHS Plan;

(B) Information, education, and training about the individual's disability, medical, and behavioral conditions; and

(C) Organized conferences and workshops specifically related to the individual's disability, identified support needs, or specialized medical or behavioral support needs.

(b) Family training services may be provided in various settings by various means, including but not limited to psychologists licensed under ORS 675.030, professionals licensed to practice medicine under ORS 677.100 or nursing under ORS 678.040, social workers licensed under ORS 675.530, or counselors licensed under ORS 675.715;

(c) Examples of what family training services do not provide include, but are not limited to:

(A) Mental health counseling, treatment, or therapy;

(B) Training for paid caregivers;

(C) Legal fees;

(D) Training for families to carry out educational activities in lieu of school;

(E) Vocational training for family members; and

(F) Paying for training to carry out activities that constitute abuse of an adult.

(d) Prior authorization by the CDDP is required for attendance by family members at organized conferences and workshops funded with IHS funds.

(e) Family training may not be provided to paid caregivers.

(24) OCCUPATIONAL THERAPY. Occupational therapy services are the services of a professional licensed under ORS 675.240 that are defined and approved for purchase under the approved State Medicaid Plan, except that the limitation on amount, duration, and scope in the plan do not apply. These services are available to maintain an individual's skills or physical condition when prescribed by a physician and after the service limits of the State Medicaid Plan have been reached, either through private or public resources.

(a) Occupational therapy services include assessment, family training, consultation, and hands-on direct therapy provided by an appropriately licensed or certified occupational therapist when there is written proof that the Oregon Health Plan service limits have been reached.

(b) Occupational therapy services do not include:

(A) Goods and services available through other public programs (e.g. OHP, schools, or Federal assistance programs) for which an individual is eligible or through an individual's private insurance;

(B) Experimental therapy or treatments;

(C) Health and medical costs that the general public must pay;

(D) Legal fees; and

(E) Education services for an individual such as tuition to schools.

(25) PHYSICAL THERAPY. Physical therapy services are the services of a professional licensed under ORS 688.020 that are defined and approved for purchase under the approved State Medicaid Plan, except that the limitation on amount, duration, and scope in the plan do not apply. These services are available to maintain an individual's skills or physical condition when prescribed by a physician and after the service limits of the State Medicaid Plan have been reached, either through private or public resources.

(a) Physical therapy services include assessment, family training, consultation, and hands-on direct therapy provided by an appropriately licensed or certified physical therapist when there is written proof that the Oregon Health Plan service limits have been reached.

(b) Physical therapy services do not include:

(A) Goods and services available through either public programs (e.g. OHP, schools, or Federal assistance programs) for which an individual is eligible or through an individual's private insurance;

(B) Experimental therapy or treatments;

(C) Health and medical costs that the general public must pay;

(D) Legal fees; and

(E) Education services for an individual such as tuition to schools.

(26) SPEECH, HEARING, AND LANGUAGE SERVICES. Speech, hearing, and language services are the services of a professional licensed under ORS 681.250 that are defined and approved for purchase under the approved State Medicaid Plan, except that the limitation on amount, duration, and scope specified in the plan do not apply. These services are available to maintain an individual's skills or physical condition when prescribed by a physician and after the service limits of the State Medicaid Plan have been reached, either through private or public resources.

(a) Speech, hearing, and language services include assessment, family training, consultation, and hands-on direct therapy provided by an appropriately licensed or certified speech therapy professional when there is written proof that the Oregon Health Plan service limits have been reached.

(b) Speech, hearing, and language services do not include:

(A) Goods and services available through either public programs (e.g. OHP, schools, or Federal assistance programs) for which an individual is eligible, or through an individual's private insurance;

(B) Experimental therapy or treatments;

(C) Health and medical costs that the general public must pay;

(D) Legal fees; and

(E) Education services for an individual such as tuition to schools.

(27) Educational services for school age individuals, such as professional instruction, formal training, and tutoring in communication, socialization, and academic skills are not allowable expenses covered by support services funds.

(28) CONDITIONS OF PURCHASE. The brokerage must arrange for supports purchased with support services funds to be provided:

(a) In settings and under contractual conditions that allow the individual to freely choose to receive supports and services from another qualified provider;

(A) Individuals who choose to combine support services funds to purchase group services must receive written instruction from the brokerage about the limits and conditions of such arrangements;

(B) Combined support services funds cannot be used to purchase existing, or create new, comprehensive services;

(C) Individual support expenses must be separately projected, tracked, and expensed, including separate contracts, employment agreements, and timekeeping for staff working with more than one individual;

(D) A provider organization resulting from the combined arrangements for community living and inclusion supports or supported employment services must be certified according to these rules; and

(E) Combined arrangements for residential supports must include a plan for maintaining an individual at home after the loss of roommates.

(b) In a manner consistent with positive behavioral theory and practice and where behavior intervention is not undertaken unless the behavior:

(A) Represents a risk to health and safety of the individual or others;

(B) Is likely to continue and become more serious over time;

(C) Interferes with community participation;

(D) Results in damage to property; or

(E) Interferes with learning, socializing, or vocation.

(c) In accordance with applicable state and federal wage and hour regulations in the case of personal services, training, and supervision;

(d) In accordance with applicable state or local building codes in the case of environmental accessibility adaptations to the home;

(e) In accordance with Oregon Board of Nursing rules in OAR chapter 851 when services involve performance of nursing services or delegation, teaching, and assignment of nursing tasks;

(f) In accordance with OAR 411-340-0160 through 411-340-0180 governing provider qualifications and responsibilities; and

(g) In accordance with the Department's Support Services Expenditure Guidelines.

(29) INDEPENDENT PROVIDER, PROVIDER ORGANIZATION, AND GENERAL BUSINESS PROVIDER AGREEMENTS AND RESPONSIBILITIES. When support services funds are used to purchase services, training, supervision, or other personal assistance for individuals, the brokerage must require and document that providers are informed of:

(a) Mandatory reporter responsibility to report suspected abuse;

(b) Responsibility to immediately notify the person or persons, if any, specified by the individual or the individual's legal representative of any injury, illness, accident, or unusual circumstance that occurs when the provider is providing individual services, training, or supervision that may have a serious effect on the health, safety, physical or emotional well-being, or level of services required;

(c) Limits of payment:

(A) Support services fund payments for the agreed-upon services are considered full payment and the provider under no circumstances may demand or receive additional payment for these services from the individual, the individual's family, or any other source unless the payment is a financial responsibility (spend-down) of an individual under the Medically Needy Program; and

(B) The provider must bill all third party resources before using support services funds unless another arrangement is agreed upon by the brokerage and described in the ISP.

(d) The provisions of OAR 411-340-0130(9) of this rule regarding sanctions that may be imposed on providers; and

(e) The requirement to maintain a drug-free workplace.

(30) SANCTIONS FOR INDEPENDENT PROVIDERS, PROVIDER ORGANIZATIONS, AND GENERAL BUSINESS PROVIDERS.

(a) A sanction may be imposed on a provider when the brokerage determines that, at some point after the provider's initial qualification and authorization to provide supports purchased with support services funds, the provider has:

(A) Been convicted of any crime that would have resulted in an unacceptable criminal records check upon hiring or authorization of service;

(B) Been convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;

(C) Surrendered his or her professional license or had his or her professional license suspended, revoked, or otherwise limited;

(D) Failed to safely and adequately provide the authorized services;

(E) Had a founded report of child abuse or substantiated abuse;

(F) Failed to cooperate with any Department or brokerage investigation or grant access to or furnish, as requested, records or documentation;

(G) Billed excessive or fraudulent charges or been convicted of fraud;

(H) Made false statement concerning conviction of crime or substantiation of abuse;

(I) Falsified required documentation;

(J) Failed to comply with the provisions of OAR 411-340-0130(8) of this rule or OAR 411-340-0140; or

(K) Been suspended or terminated as a provider by another division within the Department or Oregon Health Authority.

(b) The following sanctions may be imposed on a provider:

(A) The provider may no longer be paid with support services funds;

(B) The provider may not be allowed to provide services for a specified length of time or until specified conditions for reinstatement are met and approved by the brokerage or the Department, as applicable; or

(C) The brokerage may withhold payments to the provider.

(c) If the brokerage makes a decision to sanction a provider, the brokerage must notify the provider by mail of the intent to sanction.

(d) The provider may appeal a sanction within 30 days of the date the sanction notice was mailed to the provider. The provider must appeal a sanction separately from any appeal of audit findings and overpayments.

(A) A provider of Medicaid services may appeal a sanction by requesting an administrative review by the Department's Administrator.

(B) For an appeal regarding provision of Medicaid services to be valid, written notice of the appeal must be received by the Department within 30 days of the date the sanction notice was mailed to the provider.

(e) At the discretion of the Department, providers who have previously been terminated or suspended by any Department division or by the Oregon Health Authority may not be authorized as providers of Medicaid services.

Stat. Auth.: ORS 409.050 & 410.070

Stats. Implemented: ORS 427.005, 427.007 & 430.610 – 430.695

Hist.: MHD 9-2001(Temp), f. 8-30-01, cert. ef. 9-1-01 thru 2-27-02; MHD 5-2002, f. 2-26-02 cert. ef. 2-27-02; MHD 4-2003(Temp); f. & cert. ef. 7-1-03 thru 12-27-03; Renumbered from 309-041-1870, SPD 22-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 10-2004(Temp), f. & cert. ef. 4-30-04 thru 10-25-04; SPD 32-2004, f. & cert. ef. 10-25-04; SPD 38-2004(Temp), f. 12-30-04, cert. ef. 1-1-05 thru 6-30-05; SPD 8-2005, f. & cert. ef. 6-23-05; SPD 17-2006, f. 4-26-06, cert. ef. 5-1-06; SPD 21-2007(Temp), f. 12-31-07, cert. ef. 1-1-08 thru 6-29-08; SPD 8-2008, f. 6-27-08, cert. ef. 6-29-08; SPD 8-2009, f. & cert. ef. 7-1-09; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 5-2010, f. 6-29-10, cert. ef. 7-1-10; SPD 27-2011, f. & cert. ef. 12-28-11; SPD 13-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-340-0150

Standards for Support Services Brokerage Administration and Operations

(1) POLICY OVERSIGHT GROUP. The brokerage must develop and implement procedures for incorporating the direction, guidance, and advice of individuals and family members of individuals in the administration of the organization.

(a) The brokerage must establish and utilize a Policy Oversight Group, of which the membership majority must be individuals with intellectual or developmental disabilities and family members of individuals with intellectual or developmental disabilities.

(b) Brokerage procedures must be developed and implemented to assure the Policy Oversight Group has the maximum authority that may be legally assigned or delegated over important program operational decisions, including such areas as program policy development, program planning and goal setting, budgeting and resource allocation, selection of key personnel, program evaluation and quality assurance, and complaint resolution.

(c) If the Policy Oversight Group is not also the governing body of the brokerage, then the brokerage must develop and implement a written procedure that describes specific steps of appeal or remediation to resolve conflicts between the Policy Oversight Group and the governing body of the brokerage.

(d) A Policy Oversight Group must develop and implement operating policies and procedures.

(2) FULL-TIME BROKERAGE DIRECTOR REQUIRED. The brokerage must employ a full-time director who is responsible for daily brokerage operations in compliance with these rules and has authority to make budget, staffing, policy, and procedural decisions for the brokerage.

(3) DIRECTOR QUALIFICATIONS. In addition to the general staff qualifications of OAR 411-340-0070(1) through (2), the brokerage director must have:

(a) A minimum of a bachelor's degree and two years experience, including supervision, in intellectual or developmental disabilities, social services, mental health, or a related field; or

(b) Six years of experience, including supervision, in the field of intellectual or developmental disabilities, social services, or mental health.

(4) FISCAL INTERMEDIARY REQUIREMENTS.

(a) A fiscal intermediary must:

(A) Demonstrate a practical understanding of laws, rules, and conditions that accompany the use of public resources;

(B) Develop and implement accounting systems that operate effectively on a large scale as well as track individual budgets;

(C) Establish and meet the time lines for payments that meet individuals' needs;

(D) Develop and implement an effective payroll system, including meeting payroll-related tax obligations;

(E) Generate service, management, and statistical information and reports required by the brokerage director and Policy Oversight Group to effectively manage the brokerage and by individuals to effectively manage supports;

(F) Maintain flexibility to adapt to changing circumstances of individuals; and

(G) Provide training and technical assistance to individuals as required and specified in ISPs.

(b) A fiscal intermediary may not recruit, hire, supervise, evaluate, dismiss, or otherwise discipline those employed to provide services described in an authorized ISP.

(c) Fiscal intermediary qualifications.

(A) A fiscal intermediary may not:

(i) Be a provider of support services paid using support funds; or

(ii) Be a family member or other representative of an individual for whom they provide fiscal intermediary services.

(B) The brokerage must obtain and maintain written evidence that:

(i) Contractors providing fiscal intermediary services have sufficient education, training, or work experience to effectively and efficiently perform all required activities; and

(ii) Employees providing fiscal intermediary services have sufficient education, training, or work experience to effectively and efficiently perform all required activities prior to hire or that the brokerage has provided requisite education, training, and experience.

(5) PERSONAL AGENT QUALIFICATIONS.

(a) Each personal agent must have knowledge of the public service system for developmental disability services in Oregon and --

(A) Bachelor's degree in a Behavioral Science, Social Science, or a closely related field; OR

(B) Bachelor's degree in any field and one year of human services related experience (i.e., work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house); OR

(C) Associate's degree in a Behavioral Science, Social Science or a closely related field AND two years of human services related experience (i.e. work providing assistance to individuals and groups with issues such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate housing); OR

(D) Three years of human services related experience

(b) A brokerage must submit a written variance request to the Department prior to employment of a person not meeting the minimum qualifications for a personal agent set forth in subsection (a) of this section. The variance request must include:

(A) An acceptable rationale for the need to employ a person who does not meet the qualifications; and

(B) A proposed alternative plan for education and training to correct the deficiencies. The proposal must specify activities, timelines, and responsibility for costs incurred in completing the plan. A person who fails to complete a plan for education and training to correct deficiencies may not fulfill the requirements for the qualifications.

(6) PERSONAL AGENT TRAINING. The brokerage must provide or arrange for personal agents to receive training needed to provide or arrange for brokerage services, including but not limited to:

(a) Principles of self-determination;

(b) Person-centered planning processes;

(c) Identification and use of alternative support resources;

(d) Fiscal intermediary services;

(e) Basic employer and employee roles and responsibilities;

(f) Developing new resources;

(g) Major public health and welfare benefits;

(h) Constructing and adjusting individualized support budgets; and

(i) Assisting individuals to judge and improve quality of personal supports.

(7) INDIVIDUAL RECORD REQUIREMENTS. The brokerage must maintain current, up-to-date records for each individual served and must make these records available to the Department upon request. Individual records must include at minimum:

(a) Application and eligibility information received from the referring CDDP.

(b) An easily-accessed summary of basic information, including the individual's name, family name (if applicable), individual's legal representative (if applicable), address, telephone number, date of entry into the program, date of birth, sex, marital status, individual financial resource information, and plan year anniversary date.

(c) Documents related to determining eligibility for brokerage services and, for individuals whose entry into support services occurred prior to October 1, 2013 the amount of support services funds available to the individual, including basic supplement criteria if applicable.

(d) Records related to receipt and disbursement of funds, including expenditure authorizations, expenditure verification, copies of CPMS expenditure reports, and verification that providers meet the requirements of OAR 411-340-0160 through 411-340-0180.

(e) Documentation, signed by the individual or the individual's legal representative, that the individual or the individual's legal representative has been informed of responsibilities associated with the use of support services funds.

(f) Incident reports.

(g) The FNAT once completed and other assessments used to determine supports required, preferences, and resources.

(h) ISP and reviews. If the individual is unable to sign the ISP, the individual record must document that the individual was informed of the contents of the ISP and that the individual's agreement to the ISP was obtained to the extent possible.

(i) Names of those who participated in the development of the ISP. If the individual was not able to participate in the development of the ISP, the individual record must document the reason.

(j) Written service agreements. A written service agreement must be consistent with the individual's ISP and must describe at minimum:

(A) Type of service to be provided;

(B) Hours, rates, location of services, and expected outcomes of services; and

(C) Any specific individual health, safety, and emergency procedures that may be required, including action to be taken if an individual is unable to provide for the individual's own safety and is missing while in the community under the service of the contractor or provider organization.

(k) A written job description for all services to be delivered by an employee of the individual or the individual's legal representative. The written job description must be consistent with the individual's ISP and must describe at minimum:

(A) Type of service to be provided;

(B) Hours, rates, location, duration of services, and expected outcomes of services; and

(C) Any specific individual health, safety, and emergency procedures that may be required, including action to be taken if an individual is unable to provide for the individual's own safety and is missing while in the community under the service of the employee of the individual.

(l) Personal agent correspondence and notes related to resource development and plan outcomes.

(m) Progress notes. Progress notes must include documentation of the delivery of service by a personal agent to support each case service provided. Progress notes must be recorded chronologically and documented consistent with brokerage policies and procedures. All late entries must be appropriately documented. Progress notes must at a minimum include:

(A) The month, day, and year the services were rendered and the month, day, and year the entry was made if different from the date service was rendered;

(B) The name of the person receiving service;

(C) The name of the brokerage, the person providing the service (i.e., the personal agent's signature and title), and the date the entry was recorded and signed;

(D) The specific services provided and actions taken or planned, if any;

(E) Place of service. Place of service means the name of the brokerage and where the brokerage is located, including the address. The place of service may be a standard heading on each page of the progress notes; and

(F) The names of other participants (including titles and agency representation, if any) in notes pertaining to meetings with or discussions about the individual.

(n) Information about individual satisfaction with personal supports and the brokerage services.

(8) SPECIAL RECORD REQUIREMENTS FOR SUPPORT SERVICES FUND EXPENDITURES.

(a) The brokerage must develop and implement written policies and procedures concerning use of support services funds. These policies and procedures must include but may not be limited to:

(A) Minimum acceptable records of expenditures:

(i) Itemized invoices and receipts to record purchase of any single item;

(ii) A trip log indicating purpose, date, and total miles to verify vehicle mileage reimbursement;

(iii) Itemized invoices for any services purchased from independent contractors, provider organizations, and professionals. Itemized invoices must include:

(I) The name of the individual to whom services were provided;

(II) The date of the services; and

(III) A description of the services.

(iv) Pay records, including timesheets signed by both employee and employer, to record employee services; and

(v) Documentation that services provided were consistent with the authorized ISP.

(B) Procedures for confirming the receipt, and securing the use of, specialized medical equipment and environmental accessibility adaptations.

(i) When equipment is obtained for the exclusive use of an individual, the brokerage must record the purpose, final cost, and date of receipt.

(ii) The brokerage must secure use of equipment or furnishings costing more than $500 through a written agreement between the brokerage and the individual or the individual's legal representative that specifies the time period the item is to be available to the individual and the responsibilities of all parties should the item be lost, damaged, or sold within that time period.

(iii) The brokerage must ensure that projects for environmental accessibility adaptations involving renovation or new construction in an individual's home costing $5,000 or more per single instance or cumulatively over several modifications:

(I) Are approved by the Department before work begins and before final payment is made;

(II) Are completed or supervised by a contractor licensed and bonded in Oregon; and

(III) That steps are taken as prescribed by the Department for protection of the Department's interest through liens or other legally available means.

(iv) The brokerage must obtain written authorization from the owner of a rental structure before any environmental accessibility adaptations are made to that structure.

(b) Any goods purchased with support services funds that are not used according to an ISP or according to an agreement securing the state's use may be immediately recovered. Failure to furnish written documentation upon written request from the Department, the Oregon Department of Justice Medicaid Fraud Unit, Centers for Medicare and Medicaid Services, or their authorized representatives immediately or within timeframes specified in the written request may be deemed reason to recover payments or deny further assistance.

(9) QUALITY ASSURANCE.

(a) The Policy Oversight Group must develop a Quality Assurance Plan and review this plan at least twice a year. The Quality Assurance Plan must include a written statement of values, organizational outcomes, activities, and measures of progress that:

(A) Uses information from a broad range of consumer, advocate, professional, and other sources to determine community support needs and preferences;

(B) Involves individuals in ongoing evaluation of the quality of their personal supports; and

(C) Monitors:

(i) Customer satisfaction with the services of the brokerage and with individual plans in areas such as individual access to supports, sustaining important personal relationships, flexible and unique support strategies, individual choice and control over supports, responsiveness of the brokerage to changing needs, and preferences of individuals; and

(ii) Service outcomes in areas such as achievement of personal goals and effective use of resources.

(b) The brokerage must participate in statewide evaluation, quality assurance, and regulation activities as directed by the Department.

(10) BROKERAGE REFFERRAL TO AFFILIATED ENTITIES.

(a) When a brokerage is part of, or otherwise directly affiliated with, an entity that also provides services which an individual may purchase using private or support services funds, brokerage staff may not refer, recommend, or otherwise encourage the individual to utilize this entity to provide services unless:

(A) The brokerage conducts a review of provider options that demonstrates that the entity's services shall be cost-effective and best-suited to provide those services determined by the individual to be the most effective and desirable for meeting needs and circumstances represented in the ISP; and

(B) The entity is freely selected by the individual and is the clear choice by the individual among all available alternatives.

(b) The brokerage must develop and implement a policy that addresses individual selection of an entity of which the brokerage is a part or otherwise directly affiliated to provide services purchased with private or support services funds. This policy must address, at minimum:

(A) Disclosure of the relationship between the brokerage and the potential provider;

(B) Provision of information about all other potential providers to the individual without bias;

(C) A process for arriving at the option for selecting the provider;

(D) Verification of the fact that the providers were freely chosen among all alternatives;

(E) Collection and review of data on services, purchased by an individual enrolled in the brokerage, by an entity of which the brokerage is a part or otherwise directly affiliated; and

(F) Training of personal agents and individuals in issues related to selection of providers.

(11) GENERAL OPERATING POLICIES AND PRACTICES. The brokerage must develop and implement such written statements of policy and procedure in addition to those specifically required by this rule as are necessary and useful to enable the brokerage to accomplish its objectives and to meet the requirements of these rules and other applicable standards and rules.

Stat. Auth.: ORS 409.050 & 410.070

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Hist.: MHD 9-2001(Temp), f. 8-30-01, cert. ef. 9-1-01 thru 2-27-02; MHD 5-2002, f. 2-26-02 cert. ef. 2-27-02; MHD 4-2003(Temp); f. & cert. ef. 7-1-03 thru 12-27-03; Renumbered from 309-041-1890, SPD 22-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 32-2004, f. & cert. ef. 10-25-04; SPD 8-2005, f. & cert. ef. 6-23-05; SPD 17-2006, f. 4-26-06, cert. ef. 5-1-06; SPD 21-2007(Temp), f. 12-31-07, cert. ef. 1-1-08 thru 6-29-08; SPD 8-2008, f. 6-27-08, cert. ef. 6-29-08; SPD 8-2009, f. & cert. ef. 7-1-09; SPD 27-2011, f. & cert. ef. 12-28-11; SPD 13-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

Rule Caption: Medicaid Services — Home and Community-Based Waivered and State Plan Services
Adm. Order No.: SPD 14-2013(Temp)
Filed with Sec. of State: 7-1-2013
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Rules Amended: 411-001-0510, 411-015-0005, 411-015-0008, 411-015-0015, 411-015-0100, 411-030-0070, 411-030-0100, 411-040-0000, 411-045-0010, 411-045-0050, 411-048-0150, 411-048-0160, 411-048-0170, 411-065-0000, 411-070-0033
Subject: The Department of Human Services (Department) is immediately amending the rules for Aging and People with Disabilities (APD) in OAR chapter 411 to be in compliance with new Medicaid authority to provide both home and community-based waivered and state plan services.
Rules Coordinator: Christina Hartman—(503) 945-6398

411-001-0510
Lay Representation in Contested Case Hearings

(1) Subject to the approval of the Attorney General, an officer or employee of the Department of Human Services (Department) is authorized to appear on behalf of the Department in the following types of hearings conducted by the Office of Administrative Hearings:

(a) Eligibility for services available through a waiver or state plan administered by the Department's Aging and People with Disabilities (APD) or Developmental Disabilities (DD), including but not limited to the level or amount of benefits, and effective date;

(b) Eligibility for medical benefits, the level and amount of benefits, and effective date;

(c) Overpayments related to waivered or state plan service benefits or medical benefits;

(d) Suspension, reduction, or denial of medical assistance services, prior authorizations, or medical management decisions; and

(e) Consumer-employed provider matters, including but not limited to provider enrollment or denial of enrollment, overpayment determinations, audits, and sanctions.

(2) A Department officer or employee acting as the Department's representative may not make legal argument on behalf of the Department.

(a) "Legal argument" includes arguments on:

(A) The jurisdiction of the Department to hear the contested case;

(B) The constitutionality of a statute or rule or the application of a constitutional requirement to the Department; and

(C) The application of court precedent to the facts of the particular contested case proceeding.

(b) "Legal argument" does not include presentation of motions, evidence, examination and cross-examination of witnesses, or presentation of factual arguments or arguments on:

(A) The application of the statutes or rules to the facts in the contested case;

(B) Comparison of prior actions of the Department in handling similar situations;

(C) The literal meaning of the statutes or rules directly applicable to the issues in the contested case;

(D) The admissibility of evidence; and

(E) The correctness of procedures being followed in the contested case hearing.

(3) When an officer or employee appears on behalf of the Department, the administrative law judge shall advise the Department's representative of the manner in which objections may be made and matters preserved for appeal. Such advice is of a procedural nature and does not change applicable law on waiver or the duty to make timely objection.

(4) If the administrative law judge determines that statements or objections made by the Department representative appearing under section (1) of this rule involve legal argument as defined in this rule, the administrative law judge shall provide reasonable opportunity for the Department representative to consult the Attorney General and permit the Attorney General to present argument at the hearing or to file written legal argument within a reasonable time after conclusion of the hearing.

(5) The Department is subject to the Code of Conduct for Non-Attorney Representatives at Administrative Hearings, which is maintained by the Oregon Department of Justice and available on its website at http://www.doj.state.or.us. A Department representative appearing under section (1) of this rule must read and be familiar with the Code of Conduct for Non-Attorney Representatives at Administrative Hearings.

(6) When a Department officer or employee represents the Department in a contested case hearing, requests for admission and written interrogatories are not permitted.

Stat. Auth: ORS 409.050
Stats Implemented: ORS 183.452 & 409.010
Hist.: SPD 6-2013, f. & cert. ef. 4-2-13; SPD 14-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-015-0005
Definitions

(1) "Aging and People with Disabilities Division (APD)" means the part of the Department of Human Services responsible for the administration of programs to older adults and individuals with physical disabilities. Many of the services are provided to individuals through local Area Agency on Aging (AAA) and disability (AAAD) offices. The term "Aging and People with Disabilities Division" is synonymous with "Seniors and People with Disabilities Division" and "Department".

(2) "All Phases" means each part of an activity.

(3) "Alternative Service Resources" means other possible resources for the provision of services to meet the individual's needs. This includes, but is not limited to, natural supports (relatives, friends, significant others, roommates, neighbors or the community), Risk Intervention services, Older Americans Act programs, or other community supports. Alternative Service Resources are not paid by Medicaid.

(4) "Architectural Modifications" means any service leading to the alteration of the structure of a dwelling to meet the specific service need of the eligible individual.

(5) "Area Agency on Aging (AAA)" means the Department designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to seniors and possibly individuals with disabilities in a planning and service area. For purposes of these rules, the term Area Agency on Aging (AAA) is inclusive of both Type A and Type B Area Agencies on Aging as defined in ORS 410.040 through 410.300.

(6) "Assistance Types" needed for activities of daily living and instrumental activities of daily living include, but are not limited to the following terms:

(a) "Cueing" means giving verbal or visual clues during the activity to help the individual complete activities without hands-on assistance.

(b) "Hands-on" means a provider physically performs all or parts of an activity because the individual is unable to do so.

(c) "Monitoring" means a provider must observe the individual to determine if intervention is needed.

(d) "Reassurance" means to offer encouragement and support.

(e) "Redirection" means to divert the individual to another more appropriate activity.

(f) "Set-up" means getting personal effects, supplies, or equipment ready so that an individual can perform an activity.

(g) "Stand-by" means a provider must be at the side of an individual ready to step in and take over the task should the individual be unable to complete the task independently.

(h) "Support" means to enhance the environment to enable the individual to be as independent as possible.

(7) "Assistive Devices" means any category of durable medical equipment, mechanical apparatus, electrical appliance, or instrument of technology used to assist and enhance an individual's independence in performing any activity of daily living (ADL). This definition includes the use of service animals, general household items or furniture to assist the individual.

(8) "Behavioral Care Plan" means a documented set of procedures, reviewed by the Department or AAA representative, which describes interventions for use by the provider to prevent, mitigate or respond to behavioral symptoms that negatively impact the health and safety of an individual or others in the home or community-based services setting. The preferences of the individual should be included in developing the plan.

(9) "Business Days and Hours" means Monday through Friday and excludes Saturdays, Sundays and state or federal holidays. Hours are from 8:00 AM to 5:00 PM.

(10) "Case Manager" means a Department or AAA employee who assesses the service needs of an applicant or eligible individual, determines eligibility and offers service choices to eligible individuals. The Case Manager authorizes and implements the service plan and monitors the services delivered.

(11) "Client Assessment and Planning System (CA/PS)" is a single entry data system used for completing a comprehensive and holistic assessment, surveying the individual's physical, mental, and social functioning, and identifying risk factors, individual choices and preferences, and the status of service needs. The CA/PS documents the level of need and calculates the individual's service priority level in accordance with OAR chapter 411, division 015 rules, calculates the service payment rates, and accommodates individual participation in service planning.

(12) "Cost Effective" means being responsible and accountable with Department resources. This is accomplished by offering less costly alternatives when providing choices that adequately meet an individual's service needs. Those choices consist of the available services on the Department's published rate schedule, the utilization of assistive devices or architectural modifications and alternative service resources. Less costly alternatives may include resources not paid for by the Department.

(13) "Department" means the Department of Human Services (DHS). The term "Department" is synonymous with "Seniors and People with Disabilities Division (SPD)" and "Aging and People with Disabilities Division".

(14) "Extraordinary Circumstances" means:

(a) The individual being assessed is working full time during business hours; or

(b) A family member, whose presence is requested by the individual being assessed, is traveling from outside the area and is available for only a limited period of time which does not include business days and hours.

(15) "Functional Impairment" means an individual's pattern of mental and physical limitations that restricts the individual's ability to perform activities of daily living and instrumental activities of daily living without the assistance of another person.

(16) "Independent" means the individual does not meet the definition of "Assist" or "Full Assist" when assessing an Activity of Daily Living as defined in OAR 411-015-0006 or, when assessing an Instrumental Activity of Daily Living as defined in OAR 411-015-0007.

(17) "Individual" means the person applying or eligible for services. "Client" is synonymous with individual.

(18) "Mental or Emotional Disorder" means a schizophrenic, mood, paranoid, panic or other anxiety disorder; somatoform, personality, dissociative, factitious, eating, sleeping, impulse control or adjustment disorder or other psychotic disorder, as defined in the Diagnostic and Statistical Manual, published in 1994 by the American Psychiatric Association.

(19) "Natural Supports" or "Natural Support System" means the resources available to an individual from their relatives, friends, significant others, neighbors, roommates and the community. Services provided by natural supports are resources not paid for by the Department. Exceptions are permitted in the Independent Choices Program defined in OAR chapter 411, division 036, at service re-assessments only.

(20) "Service Priority Level (SPL)" means the order in which Department and AAA staff identifies individuals eligible for a Nursing Facility, Oregon Project Independence, or home and community-based waivered or state plan services. A lower service priority level number indicates greater or more severe functional impairment. The number is synonymous with the service priority level.

(21) "Service Setting" means a Medicaid contracted facility at which the Medicaid eligible individual resides and receives services. Service settings are adult foster homes, residential care facilities, assisted living facilities, specialized living contracted residences and nursing facilities.

(22) "Substance Abuse Related Disorders" means disorders related to the taking of a drug or toxin of abuse (including alcohol) and the side effects of medication. These disorders include substance dependency and substance abuse, alcohol dependency and alcohol abuse, substance induced disorders and alcohol induced disorders as defined in the Diagnostic and Statistical Manual, published in 1994 by the American Psychiatric Association. Substance abuse related disorders are not considered physical disabilities. Dementia or other long term physical or health impairments resulting from substance abuse may be considered physical disabilities.

(23) "Without Supports" means lacking the assistance of another person, a care setting and its staff or an alternative service resource defined in OAR 411-015-0005.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.060, 410.070 & 414.065
Hist.: SSD 3-1985, f. & ef. 4-1-85; SSD 5-1986, f. & ef. 4-14-86; SSD 9-1986, f. & ef. 7-1-86; SSD 12-1987, f. 12-31-87, cert. ef. 1-1-88; SSD 12-1991(Temp), f. 6-28-91, cert. ef. 7-1-91; SSD 21-1991, f. 12-31-91, cert. ef. 1-1-92, Renumbered from former 411-015-0000(2)(a) - (l); SDSD 11-2002(Temp), f. 12-5-02, cert. ef. 12-6-02 thru 6-3-03; SPD 12-2003, f. 5-30-03, cert. ef. 6-4-03; SPD 16-2003(Temp), f. & cert. ef. 10-27-03 thru 4-23-04; SPD 8-2004, f. & cert. ef. 4-27-04; SPD 19-2005, f. & cert. ef. 12-29-05; SPD 19-2006, f. 5-26-06, cert. ef. 6-1-06; SPD 14-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-015-0008
Assessments

(1) ASSESSMENT. The assessment process will identify the individual's ability to perform activities of daily living, instrumental activities of

daily living (self-management tasks), and determine the individual's ability to address health and safety concerns and his or her preferences to meet needs. The case manager will conduct this assessment in accordance with standards of practices established by the Department.

(a) The case manager must assess the individual's abilities regardless of architectural modifications, assistive devices or services provided by care facilities, alternative service resources or other community providers.

(b) The time frame reference for evaluation is how the individual functioned during the thirty days prior to the assessment date, with consideration of how the person is likely to function in the thirty days following the assessment date:

(A) An individual must have demonstrated the need for the assistance of another person within the assessment time frame and expect the need to be on-going beyond the assessment time frame, in order to be eligible.

(B) The time frame for assessing the Cognition/Behavior Activity of Daily Living may be extended as noted in OAR 411-015-0006.

(c) The assessment will be conducted by a case manager or other qualified Department or Area Agency on Aging representative no less than annually, with a standardized assessment tool approved by the Department.

(d) The initial assessment will be conducted face to face in the individual's home or care setting. Annual re-assessments will be conducted face to face in the individual's home or care setting unless there is a compelling reason to meet elsewhere and the individual requests an alternative location. Case Managers are required to visit the individual's home or care setting to complete the re-assessment and identify service plan needs, as well as safety and risk concerns.

(e) Effective July 1, 2006, individuals will be sent a notice of the need for re-assessment a minimum of fourteen (14) days in advance. Re-assessments based on a change in the individual's condition or needs are exempt from the 14-day advance notice requirement.

(f) The individual being assessed may request the presence of natural supports at any assessment.

(g) Assessment times will be scheduled within business days and hours unless extraordinary circumstances necessitate an alternate time. If an alternate time is necessary, the individual must request the after hours appointment and coordinate a mutually acceptable appointment time with the local Department or AAA office.

(2) SERVICE PLAN:

(a) The individual being assessed, others identified by the individual, and the case manager will consider the service options as well as assistive devices, architectural modifications, and other alternative service resources as defined in OAR 411-015-0005 to meet the service needs identified in the assessment process.

(b) The case manager has responsibility for determining eligibility for specific services, presenting alternatives to the individual, identifying risks and assessing the cost effectiveness of the plan. The case manager will monitor the plan and make adjustments as needed based on the service needs of the individual.

(c) The eligible individual, or their representative, has the responsibility to choose and assist in developing less costly service alternatives.

(d) The Service Plan payment will be considered full payment for the services rendered under Title XIX. Under no circumstances may any provider demand or receive additional payment for Title XIX-covered services from the eligible individual or any other source.

(3) The applicant or their representative has the responsibility to participate in and provide information necessary to complete assessments and re-assessments within the time frame requested by the Department. Failure to participate in or provide requested assessment or re-assessment information within the application time frame will result in a denial of service eligibility for a Nursing Facility or home and community-based waivered or state plan services. The Department may allow additional time if there are circumstances beyond the control of the individual or the individual's representative which prevent timely participation or timely submission of information.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SPD 19-2006, f. 5-26-06, cert. ef. 6-1-06; SPD 14-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-015-0015
Current Limitations

The Department has the authority to establish by Administrative Rule service eligibility within which to manage its limited resources. The Department is currently able to serve:

(1) Individuals determined eligible for OSIPM who are assessed as meeting at least one of the service priority levels (1) through (13) as defined in OAR 411-015-0010.

(2) Individuals eligible for Oregon Project Independence funded services if they meet at least one of the service priority levels (1) through (18) of OAR 411-015-0010.

(3) Individuals needing Risk Intervention Services in areas designated to provide such services. Individuals with the lowest service priority level number under OAR 411-015-0010 will be served first.

(4) The following persons:

(a) Individuals sixty-five years of age or older determined eligible for Developmental Disability services or having a primary diagnosis of a mental or emotional disorder are eligible for nursing facility or home and community-based waivered or state plan services if they meet sections (1), (2), or (3) of this rule and are not in need of specialized mental health treatment services or other specialized Department residential program intervention as identified through the PASRR process defined in OAR 411-070-0043 or mental health assessment process.

(b) Individuals under sixty-five years of age determined eligible for developmental disability services or having a primary diagnosis of a mental or emotional disorder are not eligible for Department nursing facility services unless determined appropriate through the PASRR process defined in OAR 411-070-0043.

(c) Individuals under sixty-five years of age determined to be eligible for developmental disabilities services are not eligible for home and community-based waivered or state plan services administered by the Department's Aging and People with Disabilities Division. Eligibility for home and community-based waivered or state plan services for individuals with intellectual or developmental disabilities is determined by the Department's Office of Developmental Disabilities or designee.

(d) Individuals under sixty-five years of age who have a diagnosis of mental or emotional disorder or substance abuse related disorder are not eligible for home and community-based waivered or state plan services unless:

(A) They have a medical non-psychiatric diagnosis or physical disability; and

(B) Their need for services is based on their medical non-psychiatric diagnosis or physical disability; and

(C) They provide supporting documentation demonstrating that their need for services is based on the medical, non-psychiatric diagnosis or physical disability. The Department will authorize documentation sources through approved and published policy transmittals.

(5) Home and community-based waivered or state plan services are not intended to replace the resources available to an individual from their natural support system. Natural supports are voluntary in nature and must not be assumed. Natural supports must have the skills and abilities to perform the services needed by an individual. Individuals whose service needs are met by their alternative service resources are not eligible for home and community-based waivered or state plan services. Services may be authorized only when the alternative service resources are unavailable, insufficient or inadequate to meet the needs of the individual.

(6) Individuals with excess income must contribute to the cost of service pursuant to OAR 461-160-0610 and 461-160-0620.

Stat. Auth.: ORS 410.070 & 411.070
Stats. Implemented: ORS 410.070
Hist.: SSD 3-1985, f. & ef. 4-1-85; SSD 5-1986, f. & ef. 4-14-86; SSD 9-1986, f. & ef. 7-1-86; SSD 12-1987, f. 12-31-87, cert. ef. 1-1-88; SSD 12-1991(Temp), f. 6-28-91, cert. ef. 7-1-91; SSD 21-1991, f. 12-31-91, cert. ef. 1-1-92, Renumbered from former 411-015-0000(4); SSD 1-1993, f. 3-19-93, cert. ef. 4-1-93; SDSD 11-2002(Temp), f. 12-5-02, cert. ef. 12-6-02 thru 6-3-03; SPD 1-2003(Temp), f. 1-7-03, cert. ef. 2-1-03 thru 6-3-03; SDP 3-2003(Temp), f. 2-14-03, cert. ef. 2-18-03 thru 6-3-03; SPD 5-2003(Temp), f. & cert. ef. 3-12-03 thru 6-3-03; SPD 6-2003(Temp), f. & cert. ef. 3-20-03 thru 6-3-03; SPD 12-2003, f. 5-30-03, cert. ef. 6-4-03; SPD 16-2003(Temp), f. & cert. ef. 10-27-03 thru 4-23-04; SPD 5-2004(Temp), f. & cert. ef. 3-23-04 thru 4-27-04; SPD 8-2004, f. & cert. ef. 4-27-04; SPD 20-2004(Temp), f. & cert. ef. 7-7-04; SPD 29-2004(Temp), f. & cert. ef. 8-6-04 thru 1-3-05; SPD 1-2005, f. & cert. ef. 1-4-05; SPD 8-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 19-2006, f. 5-26-06, cert. ef. 6-1-06; SPD 14-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-015-0100
Eligibility for Nursing Facility or Home and Community-Based Waivered or State Plan Services

(1) To be eligible for nursing facility services or home and community-based waivered or state plan services, a person must:

(a) Be age 18 or older; and

(b) Be eligible for OSIPM; and

(c) Meet the functional impairment level within the service priority levels currently served by the Department as outlined in OAR 411-015-0010 and the requirements in OAR 411-015-0015; or

(d) To be eligible to have services paid through the State Spousal Pay Program, the person must meet requirements as listed above in subsection (a), (b), & (c), and in addition, the requirements in OAR 411-030-0080.

(2) Individuals who are age 17 or younger and reside in a nursing facility are eligible for nursing facility services only. They are not eligible to receive home and community-based waivered or state plan services.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.060, 410.070 & 414.065
Hist.: SSD 7-1991(Temp), f. & cert. ef. 4-1-91; SSD 13-1991, f. 6-28-91, cert. ef. 7-1-91; SDSD 11-2002(Temp), f. 12-5-02, cert. ef. 12-6-02 thru 6-3-03; SPD 1-2003(Temp), f. 1-7-03, cert. ef. 2-1-03 thru 6-3-03; SPD 12-2003, f. 5-30-03, cert. ef. 6-4-03; SPD 17-2003(Temp), f. 10-31-03, cert. ef. 11-1-03 thru 4-28-04; SPD 8-2004, f. & cert. ef. 4-27-04; SPD 29-2004(Temp), f. & cert. ef. 8-6-04 thru 1-3-05; SPD 1-2005, f. & cert. ef. 1-4-05; SPD 19-2005, f. & cert. ef. 12-29-05; SPD 19-2006, f. 5-26-06, cert. ef. 6-1-06; SPD 14-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-030-0070
Maximum Hours of Service

(1) LEVELS OF ASSISTANCE FOR DETERMINING SERVICE PLAN HOURS.

(a) "Minimal Assistance" means the individual is able to perform the majority of an activity, but requires some assistance from another person.

(b) "Substantial Assistance" means the individual can perform only a small portion of the tasks that comprise the activity without assistance from another person.

(c) "Full Assistance" means the individual needs assistance from another person through all phases of the activity, every time the activity is attempted.

(2) MAXIMUM MONTHLY HOURS FOR ADL.

(a) The planning process uses the following limitations for time allotments for ADL tasks. Hours authorized must be based on the service needs of the individual. Case managers may authorize up to the amount of hours identified in these assistance levels (minimal, substantial, or full assist).

(A) Eating:
(i) Minimal assistance, 5 hours;
(ii) Substantial assistance, 20 hours;
(iii) Full assistance, 30 hours;
(B) Dressing/Grooming:
(i) Minimal assistance, 5 hours;
(ii) Substantial assistance, 15 hours;
(iii) Full assistance, 20 hours;
(C) Bathing and Personal Hygiene:
(i) Minimal assistance, 10 hours;
(ii) Substantial assistance, 15 hours;
(iii) Full assistance, 25 hours;
(D) Mobility:
(i) Minimal assistance, 10 hours;
(ii) Substantial assistance, 15 hours;
(iii) Full assistance, 25 hours;
(E) Elimination (Toileting, Bowel, and Bladder):
(i) Minimal assistance, 10 hours;
(ii) Substantial assistance, 20 hours;
(iii) Full assistance, 25 hours;
(F) Cognition/Behavior:
(i) Minimal assistance, 5 hours;
(ii) Substantial assistance, 10 hours;
(iii) Full assistance, 20 hours.

(b) Service plan hours for ADL may only be authorized for an individual if the individual requires assistance (minimal, substantial, or full assist) from another person in that activity of daily living as determined by a service assessment applying the parameters in OAR 411-015-0006.

(c) For households with two or more eligible individuals, each individual's ADL service needs must be considered separately. In accordance with section (3)(c) of this rule, authorization of IADL hours shall be limited for each additional individual in the home.

(d) Hours authorized for ADL are paid at hourly rates in accordance with the rate schedule. The Independent Choices Program cash benefit is based on the hours authorized for ADLs paid at the hourly rates. Participants of the Independent Choices Program may determine their own employee provider pay rates.

(3) MAXIMUM MONTHLY HOURS FOR IADL.

(a) The planning process uses the following limitations for time allotments for IADL tasks. Hours authorized must be based on the service needs of the individual. Case managers may authorize up to the amount of hours identified in these assistance levels (minimal, substantial, or full assist).

(A) Medication and Oxygen Management:
(i) Minimal assistance, 2 hours;
(ii) Substantial assistance, 4 hours;
(iii) Full assistance, 6 hours;
(B) Transportation or Escort Assistance:
(i) Minimal assistance, 2 hours;
(ii) Substantial assistance, 3 hours;
(iii) Full assistance, 5 hours;
(C) Meal Preparation:
(i) Minimal assistance prior to January 1, 2012:
(I) Breakfast, 4 hours;
(II) Lunch, 4 hours;
(III) Supper, 8 hours.
(ii) Minimal assistance effective January 1, 2012:
(I) Breakfast, 3 hours;
(II) Lunch, 3 hours;
(III) Supper, 7 hours.
(iii) Substantial assistance prior to January 1, 2012:
(I) Breakfast, 8 hours;
(II) Lunch, 8 hours;
(III) Supper, 16 hours.
(iv) Substantial assistance effective January 1, 2012:
(I) Breakfast, 7 hours;
(II) Lunch, 7 hours;
(III) Supper, 14 hours.
(v) Full assistance prior to January 1, 2012:
(I) Breakfast, 12 hours;
(II) Lunch, 12 hours;
(III) Supper, 24 hours.
(vi) Full assistance effective January 1, 2012:
(I) Breakfast, 10 hours;
(II) Lunch, 10 hours;
(III) Supper, 21 hours.
(D) Shopping:
(i) Minimal assistance, 2 hours;
(ii) Substantial assistance, 4 hours;
(iii) Full assistance, 6 hours;
(E) Housecleaning:
(i) Minimal assistance:
(I) Prior to January 1, 2012, 5 hours.
(II) Effective January 1, 2012, 4 hours.
(ii) Substantial assistance:
(I) Prior to January 1, 2012, 10 hours.
(II) Effective January 1, 2012, 9 hours.
(iii) Full assistance:
(I) Prior to January 1, 2012, 20 hours.
(II) Effective January 1, 2012, 18 hours.

(b) Rates shall be paid in accordance with the rate schedule. When a live-in employee is present, these hours may be paid at less than minimum wage according to the Fair Labor Standards Act. The Independent Choices Program cash benefit is based on the hours authorized for IADL tasks paid at the hourly rates. Participants of the Independent Choices Program may determine their own employee provider pay rates.

(c) When two or more individuals eligible for IADL task hours live in the same household, the assessed IADL need of each individual must be calculated. Payment shall be made for the highest of the allotments and a total of four additional IADL hours per month for each additional individual to allow for the specific IADL needs of the other individuals.

(d) Service plan hours for IADL tasks may only be authorized for an individual if the individual requires assistance (minimal, substantial, or full assist) from another person in that IADL task as determined by a service assessment applying the parameters in OAR 411-015-0007.

(4) TWENTY-FOUR HOUR AVAILABILITY.

(a) Payment for 24-hour availability shall be authorized only when an individual employs a live-in homecare worker or Independent Choices Program employee provider and requires 24-hour availability due to the following:

(A) The individual requires assistance with ADL or IADL tasks at unpredictable times throughout most 24-hour periods; and

(B) The individual requires minimal, substantial, or full assistance with ambulation and requires assistance with transfer (as defined in OAR 411-015-0006); or

(C) The individual requires full assistance in transfer or elimination (as defined in OAR 411-015-0006); or

(D) The individual requires full assist in at least three of the eight components of cognition/behavior (as defined in OAR 411-015-0006).

(b) The number of hours allowed per month shall have the following maximums. Hours authorized are based on the service needs of the indi-

vidual. Case managers may authorize up to the amount of hours identified in these assistance levels (minimal, substantial, or full assist).

(A) Minimal assistance — 60 hours. Minimal assistance hours may be authorized when an individual requires one of these assessed needs as defined in OAR 411-015-0006:

(i) Full assist in cognition; or

(ii) Full assist in toileting or bowel or bladder.

(B) Substantial assistance — 110 hours. Substantial assistance hours may be authorized when an individual requires these assessed needs as defined in OAR 411-015-0006:

(i) Assist in transfer; and

(ii) Assist in ambulation; and

(iii) Full assist in cognition; or

(iv) Full assist in toileting or bowel or bladder.

(C) Full assistance — 159 hours. Full assistance hours may be authorized when:

(i) The authorized provider cannot get at least five continuous hours of sleep in an eight hour period during a 24-hour work period; and

(ii) The eligible individual requires these assessed needs as defined in OAR 411-015-0006:

(I) Full assist in transfer; and

(II) Assist in mobility; or

(III) Full assist in toileting or bowel or bladder; or

(IV) Full assist in cognition.

(c) Service plans that include full-time live-in homecare workers or Independent Choices Program employee providers must include a minimum of 60 hours per month of 24-hour availability. When a live-in homecare worker or Independent Choices Program employee provider is employed less than full time, the hours must be pro-rated. Full-time means the live-in homecare worker is providing services to the consumer-employer seven days per week throughout a calendar month.

(d) Rates for 24-hour availability shall be in accordance with the rate schedule and paid at less than minimum wage according to the Fair Labor Standards Act and ORS 653.020.

(e) Twenty-four hour availability assumes the homecare worker is available to address the service needs of an individual as they arise throughout a 24-hour period. A homecare worker who engages in employment outside the eligible individual's home or building during the work periods the homecare worker is on duty, is not considered available to meet the service needs of the individual.

(5) Under no circumstances shall any provider receive payment from the Department for more than the total amount authorized by the Department on the service plan authorization form. All service payments must be prior-authorized by the Department/AAA.

(6) AUTHORIZED HOURS ARE SUBJECT TO THE AVAILABILITY OF FUNDS. Case managers must assess and utilize as appropriate, natural supports, cost-effective assistive devices, durable medical equipment, housing accommodations, and alternative service resources (as defined in OAR 411-015-0005) which could reduce the individual's reliance on paid in-home services hours.

(7) The Department may authorize paid in-home services only to the extent necessary to supplement potential or existing resources within the individual's natural supports system.

(8) Payment by the Department for home and community-based waivered or state plan services shall only be made for those tasks described in this rule as ADL, IADL tasks, and 24-hour availability. Services must be authorized to meet the needs of the eligible individual and may not be provided to benefit the entire household.

(9) EXCEPTIONS TO MAXIMUM HOURS OF SERVICE.

(a) To meet an extraordinary ADL service need that has been documented, the hours authorized for ADL may exceed the full assistance hours (described in section (2) of this rule) as long as the total number of ADL hours in the service plan does not exceed 145 hours per month.

(b) Monthly service payments that exceed 145 ADL hours per month may be approved by the Department when the exceptional payment criteria identified in OAR 411-027-0020 and 411-027-0050 is met.

(c) Monthly service plans that exceed 145 ADL, 76 IADL, and 159 24-hour availability hours per month for a live-in homecare worker or Independent Choices Program employee provider, or that exceed the equivalent monthly service payment for an hourly services plan, may be approved by the Department when the exceptional payment criteria identified in OAR 411-027-0020 and 411-027-0050 is met.

(d) As long as the total number of IADL task hours in the service plan does not exceed 76 hours per month and the service need is documented, the hours authorized for IADL tasks may exceed the hours for full assistance (as described in section (3) of this rule) for the following tasks and circumstances:

(A) Housekeeping based on medical need (such as immune deficiency);

(B) Short-term extraordinary housekeeping services necessary to reverse unsanitary conditions that jeopardize the health of the individual; or

(C) Extraordinary IADL needs in medication management or service-related transportation.

(e) Monthly service plans that exceed 76 hours per month in IADL tasks may be approved by the Department when the individual meets the exceptional payment criteria identified in OAR 411-027-0020 and 411-027-0050.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 409.050, 410.070 & 410.090

Stats. Implemented: ORS 410.010, 410.020 & 410.070

Hist.: SSD 4-1993, f. 4-30-93, cert. ef. 6-1-93; SSD 6-1994, f. & cert. ef. 11-15-94; SDSD 8-1999(Temp), f. & cert. ef. 10-15-99 thru 4-11-00; SDSD 3-2000, f. 4-11-00, cert. ef. 4-12-00; SPD 14-2003, f. & cert. ef. 7-31-03; SPD 15-2003 f. & cert. ef. 9-30-03; SPD 15-2004, f. 5-28-04, cert. ef. 6-7-04; SPD 15-2004, f. 5-28-04, cert. ef. 6-7-04; SPD 18-2005(Temp), f. 12-20-05, cert. ef. 12-21-05 thru 6-1-06; SPD 20-2006, f. 5-26-06, cert. ef. 6-1-06; SPD 4-2008(Temp), f. & cert. ef. 4-1-08 thru 9-24-08; SPD 13-2008, f. & cert. ef. 9-24-08; SPD 15-2008, f. 12-26-08, cert. ef. 1-1-09; SPD 24-2011(Temp), f. 11-15-11, cert. ef. 1-1-12 thru 6-29-12; SPD 6-2012, f. 5-31-12, cert. ef. 6-1-12; SPD 14-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-030-0100

Independent Choices Program

(1) The Independent Choices Program (ICP) is an In-Home Services Program that empowers participants to self-direct their own service plans and purchase goods and services that enhance independence, dignity, choice, and well-being.

(2) The ICP is limited to a maximum of 2,600 participants.

(a) The Department establishes and maintains a waiting list for individuals eligible for in-home services requesting ICP after the ICP has reached its maximum.

(b) The Department enters names on the waiting list according to the date submitted by the Department or AAA office.

(c) As vacancies occur, eligible individuals on the waiting list shall be offered the ICP in order according to their place on the waiting list.

(d) Individuals on the waiting list may receive services through other appropriate Department programs for which they are eligible.

(3) INITIAL ELIGIBILITY REQUIREMENTS.

(a) To be eligible for the ICP an individual must:

(A) Meet all program requirements of the In-Home Services Program in these rules;

(B) Develop a service plan and budget to meet the needs identified in the CA/PS assessment;

(C) Sign the ICP participation agreement;

(D) Have or be able to establish a checking account;

(E) Provide evidence of a stable living situation for the past three months; and

(F) Demonstrate the ability to manage money as evidenced by timely and current utility and housing payments.

(b) If the participant is unable to direct and purchase his or her own in-home services, the participant must have a representative to act on the participant's behalf. The "representative" is the person assigned by the participant to act as the participant's decision maker in matters pertaining to the ICP service plan and service budget. A representative must:

(A) Complete a background check pursuant to OAR chapter 407, division 007 and receive a final fitness determination of approval; and

(B) Sign and adhere to the "Independent Choices Program Representative Agreement" on behalf of the participant.

(c) If the participant is unable to manage ICP cash payment accounting, tax, or payroll responsibilities and does not have a representative, the participant must arrange and purchase the ongoing services of a fiscal intermediary, such as an accountant, bookkeeper, or equivalent financial services. Participants, or their representative, who have met the eligibility criteria in section (3)(b) of this rule, may also choose to use a fiscal intermediary. The participant is responsible for any fees or payment to the fiscal intermediary and may allocate the fees or payment from their discretionary funds or other non ICP funds.

(4) DISENROLLMENT CRITERIA. Participants may be disenrolled from the ICP voluntarily or involuntarily. Participants who are disenrolled from the ICP may not reapply for six months. After the six month disenrollment period, an individual may re-enroll and must meet all ICP eligibility requirements. If the ICP enrollment cap has been reached, participants who were disenrolled shall be added to the waiting list.

(a) Voluntary disenrollment. Participants or representatives must provide notice to the Department of intent to discontinue participation. The participant or the representative must meet with the Department to reconcile remaining ICP cash payment either within 30 days of the date of disenrollment or before the termination date, whichever is sooner.

(b) Involuntary disenrollment. The participant may be involuntarily disenrolled from the ICP when the participant, representative, or employee provider does not adequately meet the participant's service needs or carry out the following ICP responsibilities:

(A) Non-payment of employee's wages, as stated in the service budget.

(B) Failure to maintain health and well-being by obtaining personal care as evidenced by:

(i) Decline in functional status due to the failure to meet the participant's needs; or

(ii) Substantiated complaints of self-neglect or neglect or other abuse on the part of the employee provider or representative.

(C) Failure to purchase goods and services according to the service plan;

(D) Failure to comply with the legal or financial obligations as an employer;

(E) Failure to maintain a separate ICP checking account or commingling ICP cash benefit with other assets;

(F) Inability to manage the cash benefit as evidenced by two or more incidents of overdrafts of the participant's ICP checking account during the last cash benefit review period;

(G) Failure to deposit monthly service liability payment into the ICP checking account;

(H) Failure to maintain an individualized back-up plan (as part of the service plan) resulting in a negative consequence;

(I) Failure to sign or follow the ICP Participation Agreement; and

(J) Failure to select a representative within 30 days if a participant needs a representative and does not have one.

(5) INTERRUPTION OF SERVICES. When a participant is absent from the home for longer than 30 days due to illness or medical treatment, the ICP cash benefit shall be terminated. The cash benefit may resume upon return to the home, providing ICP eligibility criteria is met.

(6) SELECTION OF EMPLOYEE PROVIDERS.

(a) The participant or representative carries full responsibility for locating, screening, interviewing, hiring, training, paying, and terminating employee providers. The participant or representative must comply with Immigration and Customs Enforcement laws and policies.

(b) The participant or representative must assure the employee provider's ability to perform or assist with ADL, self-management, and twenty-four hour availability needs.

(c) Employee providers must complete a background check pursuant to OAR chapter 407, division 007. If a record of a potentially disqualifying crime is revealed, the participant or representative may employ the provider at the participant's or representative's discretion.

(d) A representative may not be an employee provider regardless of relationship to the participant.

(e) Participant's relatives may be employed as employee providers.

(7) CASH BENEFIT.

(a) The cash benefit is determined based on the CA/PS assessment of need, the service plan, the level of assistance standards in OAR 411-030-0070, and natural supports.

(b) The cash benefit is calculated by adding the ADL task hours, the self-management task hours, and the twenty-four hour availability hours that the participant is eligible for as determined in the CA/PS assessment, at the rates according to the Department's rate schedule.

(c) The following services, which are approved by the case manager and paid for by the Department, are excluded from ICP cash benefit:

(A) Community health supports;

(B) Contracted community transportation;

(C) Home delivered meals; and

(D) Emergency response systems.

(d) The cash benefit shall include the employer's portion of required FICA, FUTA, and SUTA.

(e) The cash benefit shall be directly deposited into the participant's ICP designated checking account.

(8) SERVICE BUDGET.

(a) The service budget must identify the cash benefit, the discretionary and contingency funds if applicable, the reimbursement to an employee provider, and all other expenditures. The service budget must be initially approved by Department/AAA staff.

(b) The participant may amend the service budget as long as the amendments relate to meeting the service needs and are within ICP program guidelines.

(c) A budget review to assure financial accountability and review service budget amendments must be completed at least every six months.

(9) CONTINGENCY FUND.

(a) The participant may establish a contingency fund in the service budget to purchase identified items that are not otherwise covered by Medicaid or food stamps that substitute for personal assistance and allow for greater independence.

(b) The contingency fund must be approved by the case manager, identified in the service budget, and related to service plan needs.

(c) Contingency funds may be carried over into the next month's budget until the item is purchased.

(10) DISCRETIONARY FUND.

(a) The participant may establish a monthly discretionary fund in the service budget to purchase items that directly relate to the health, safety, and independence of the participant and are not otherwise covered under home and community-based waivered or state plan services or delineated in the monthly service budget.

(b) The maximum amount of discretionary funds may be up to 10 percent of the participant's cash benefit not including employee taxes.

(c) The discretionary fund must be approved by the case manager, identified in the service budget, and related to service plan needs.

(d) Discretionary funds must be used by the end of the month.

(11) ISSUING BENEFITS.

(a) The service plan and service budget must be prior approved by the case manager before the first ICP cash benefit is paid.

(b) A cash benefit is considered issued and received by the participant when the direct deposit is made to the participant's ICP bank account or a benefit check is received by the participant.

(c) The cash benefit is exempt from resource calculations for other DHS programs only while in the ICP bank account and not commingled with other personal funds.

(d) The cash benefit is not subject to assignment, transfer, garnishment, or levy as long as it can be identified as a program benefit and is separate from other money in the participant's possession.

(12) CASE MANAGER RESPONSIBILITIES.

(a) The case manager is responsible to review and authorize service plans and service budgets that meet the ICP program criteria.

(b) If a participant is disenrolled, the case manager must review eligibility for other Medicaid home and community-based waivered and state plan service options and offer other alternatives if the participant is eligible.

(c) At least every six months, the Department/AAA staff must complete a service budget review to assure financial accountability and review service budget amendments.

(13) HEARING RIGHTS. ICP participants have contested case hearing rights as described in OAR chapter 461, division 025.

Stat. Auth.: ORS 410.090
Stats. Implemented: ORS 410.070
Hist.: SPD 4-2008(Temp), f. & cert. ef. 4-1-08 thru 9-24-08; SPD 13-2008, f. & cert. ef. 9-24-08; SPD 15-2008, f. 12-26-08, cert. ef. 1-1-09; SPD 14-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-040-0000
Home Delivered Meals

(1) Home delivered meals, exclusive of those funded through the Older Americans Act or Oregon Project Independence, constitute a service that is provided as part of home and community-based waivered or state plan services to assist an individual to remain in his or her own home.

(2) Payment for meals delivered to an individual at his or her home may be provided when other plans do not appear feasible and home delivered meals are determined by the Department's local unit to be more appropriate for the individual's needs than nursing facility services. The cost for these meals is calculated into the service plan in conjunction with in-home services provided by a consumer-employed provider or a home care agency.

(3) All requests for home delivered meals must be referred to the Department's local unit.

(4) The Department's unit staff are responsible for establishing, authorizing, purchasing, and monitoring a plan for home-delivered meals.

(5) Individuals who are required to make a monthly payment under OAR 461-185-0050 in order to remain eligible for home and community-based waivered or state plan services must have the home-delivered meal costs calculated in conjunction with the in-home service provider costs.

(a) To remain eligible for home and community-based waivered or state plan services, pay-in individuals are responsible for payment of

authorized home-delivered meals received up to their specified monthly pay-in amount. Individual payments due for meal services are to be included as part of the monthly sum sent to the Department's pay-in unit rather than making any direct payments to the meal provider.

(b) The Department is responsible for direct payments made to providers for all authorized home-delivered meals to individuals receiving home and community-based waivered or state plan services. Direct payment from the Department includes meals paid through the individual's monthly pay-in and for meals that exceed the individual's total monthly liability.

(6) For individuals whose meals are delivered through an Older Americans Act meal service program, which also contracts as a Medicaid home delivered meals provider:

(a) Individuals receiving home-delivered meals authorized and paid for by the Department must be officially informed by the case manager that there is no obligation to make any voluntary or suggested donation for this service. However, if the individual chooses to make a voluntary donation, there is no restriction from doing so.

(b) If the individual has a monthly payment to the Department under OAR 461-185-0050 in order to remain eligible for services, the criteria in both subsections (5) and (6) (a) of this rule applies to them.

(c) An individual who meets the criteria in subsections (2) or (5) of this rule and is age 65 or older, may choose to receive meals through the Older Americans Act (OAA) meal service program and can make voluntary donations. For individuals required to make a monthly payment under OAR 461-185-0050, these donations may not be credited toward the pay-in liability. In turn, OAA meal programs are not mandated to provide home-delivered meals to individuals, age 65 and older, receiving home and community-based waivered or state plan services unless the agency is a Medicaid-contracted meal provider and the meals are authorized and paid for by the Department.

Stat. Auth.: ORS 410.070, 411.060 & 411.070
Stats. Implemented: ORS 410.070
Hist.: SSD 11-1982, f. & ef. 10-1-82; SPD 12-2004, f. & cert. ef. 6-1-04; SPD 26-2011(Temp), f. & cert. ef. 12-20-11 thru 6-13-12; Administrative correction, 6-27-12; SPD 14-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-045-0010
Definitions

(1) Administrative Hearing — A hearing related to a denial, reduction, or termination of benefits that is held when requested by the PACE participant or his or her representative. A hearing may also be held when requested by a PACE participant who believes a claim for services was not acted upon with reasonable promptness or believes the payor took an action erroneously.

(2) Advance Directive — A process that allows a person to have another person make health care decisions when he or she cannot make the decision and tells a doctor what life sustaining measures to take if he or she is near death.

(3) Aging and People with Disabilities Division (APD) — A division within the Department that is the designated State Unit on Aging (SUA) that also administers Medicaid's long-term care program. APD is responsible for nursing facility and home and community-based waivered or state plan services for eligible elderly and disabled individuals. APD includes local offices and the AAAs who have contracted to perform specific functions of the licensing and enrollment processes. The term "Aging and People with Disabilities Division" is synonymous with "Seniors and People with Disabilities Division (SPD)".

(4) Alternate Service Settings — Residential 24 hour care facilities that include, but are not limited to, Residential Care Facilities, Assisted Living Facilities, Adult Foster Homes, and Nursing Facilities.

(5) Americans with Disabilities Act (ADA) — Federal law defining the civil rights of persons with disabilities. The ADA requires that reasonable accommodations be made in employment, service delivery, and facility accessibility.

(6) Ancillary Services — Those medical services that are medically appropriate to support a covered service under the PACE benefit package. A list of ancillary services and limitations is specified in DMAP's Ancillary Services Criteria Guide.

(7) Appeal — A PACE participant's action taken with respect to any instance where the PACE program reduces, terminates or denies a covered service.

(8) Area Agency on Aging (AAA) — An established public agency within a planning and service area designated under Section 305 of the Older American's Act that has responsibility for local administration of Department programs. AAAs contract with the Department to perform specific activities in relation to PACE programs including processing of applications for Medicaid and determining the level of care required under Oregon's State Medicaid Plan for coverage of nursing facility services.

(9) Assessment — The determination of a participant's need for covered services. It involves the collection and evaluation of data by each of the members of the Interdisciplinary Team pertinent to the participant's health history and current problem(s) obtained through interview, observation, and record review. The Assessment concludes with one of the following:

(a) Documentation of a diagnosis providing the clinical basis for a written care plan; or

(b) A written statement that the participant is not in need of covered services for a particular condition.

(10) Automated Information System (AIS) — A computer system that provides information on the current eligibility status for participants under the Medical Assistance Program.

(11) Centers for Medicare and Medicaid (CMS) — Formerly known as the Health Care Financing Administration (HCFA). The federal agency under the Department of Health and Human Services that is responsible for approving the PACE program and joining the state in signing an agreement with the PACE program once it has been approved as a provider under 42 CFR Part 460.

(12) Clinical Record — The clinical record includes, but is not limited to, the medical, social services, dental, and mental health records of a PACE participant. These records include the Interdisciplinary Team's records, hospital records, and grievance and disenrollment records.

(13) Comfort Care — The provision of medical services or items that give comfort or pain relief to a participant who has a terminal illness. Comfort care includes the combination of medical and related services designed to make it possible for a participant with terminal illness to die with dignity, respect, and with as much comfort as is possible given the nature of the illness. Comfort care includes but is not limited to, pain medication, palliative services, and hospice care including those services directed toward ameliorating symptoms of pain or loss of bodily function or to prevent additional pain or disability. These guarantees are provided pursuant to 45 CFR, Chapter XIII, 1340.15. Where applicable comfort care is provided consistent with Section 4751 OBRA 1990 — Patient Self-Determination Act and ORS 127.505-127.660 and 127.800-127.897 relating to health care decisions. Comfort care does not include diagnostic or curative care for the primary illness or care focused on active treatment of the primary illness and intended to prolong life.

(14) Community Standard — Typical expectations for access to the health care delivery system in the PACE participant's community of residence. Except where the community standard is less than sufficient to ensure quality of care, The Department requires that the health care delivery system available to PACE participants take into consideration the community standard and be adequate to meet the needs of PACE participants.

(15) Covered Services — Those diagnoses, treatments, and services listed in OAR 410-141-0520. In addition, all services that would be covered by Medicare must be covered even if they fall below the currently funded line for the Oregon Health Plan. Covered services must also include those services listed in 42 CFR Sections 460.92 and 460.94.

(16) Dentally Appropriate — Services that are required for prevention, diagnosis or treatment of a dental condition and that are:

(a) Consistent with the symptoms of a dental condition or treatment of a dental condition; and

(b) Appropriate with regard to standards of good dental practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of the PACE participant or a provider of the service;

(d) The most cost effective of the alternative levels of dental services that can be safely provided to a PACE participant.

(17) Dental Emergency Services — Dental services provided for severe pain, bleeding, unusual swelling of the face or gums, or an avulsed tooth.

(18) Department — For the purposes of this rule, Department will indicate the programs that contract with the PACE program: Aging and People with Disabilities (APD) and the Oregon Health Authority, Addictions and Mental Health Division (AMH) and Division of Medical Assistance Programs (DMAP).

(19) DHS — Department of Human Services (DHS).

(20) Disenrollment — The act of discharging a PACE participant from a PACE program. After the effective date of disenrollment a PACE participant is no longer authorized to obtain covered services from the PACE program.

(21) Emergency Services — The health care and services provided for diagnosis and treatment of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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 health of the individual in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

(22) Enrollment — A process for the PACE program. A PACE participant's enrollment with a PACE program indicates that the PACE participant must obtain from, or be referred by, the PACE program for all covered services.

(23) Grievance — A PACE participant's or the participant's representative's clear expression of dissatisfaction with the PACE program that addresses issues that are part of the PACE program's contractual responsibility. The expression may be in whatever form of communication or language that is used by the participant or the participant's representative but must state the reason for the dissatisfaction.

(24) Health Management Unit (HMU) — The DMAP unit responsible for adjustments to enrollments and retroactive disenrollments.

(25) Interdisciplinary Team (IDT) — PACE staff and PACE subcontractors with current and appropriate licensure, certification, or accreditation who are responsible for assessment and development of the PACE participant's care plan. These professionals may conduct assessments of PACE participants and provide services to PACE participants within their scope of practice, state licensure or certification. These persons include at least one representative from each of the following groups:

(a) Medical Doctor, Osteopathic Physician, Nurse Practitioner, or Physician's Assistant;

(b) Registered Nurse or a Licensed Practical Nurse supervised by an RN;

(c) Social Worker with a Master's degree or a Social Worker with a Bachelor degree who is supervised by a Master's level Social Worker;

(d) Occupational Therapist or a Certified Occupational Therapy Assistant supervised by an Occupational Therapist;

(e) Recreational Therapist or an Activity Coordinator with two years experience;

(f) Physical Therapist or a Physical Therapy Assistant supervised by a Physical Therapist;

(g) Dietician and Pharmacist as indicated; and

(h) In addition to the positions listed above in paragraphs (25)(a)–(g), the IDT must include the PACE Center Manager, the Home Care Coordinator, Personal Care Attendant and the Driver or Transportation Coordinator.

(26) Medicaid — A federal and state funded portion of the Medical Assistance Program established by Title XIX of the Social Security Act, as amended and administered in Oregon by the Department of Human Services.

(27) Medically Appropriate — Services and medical supplies required for prevention, diagnosis or treatment of a health condition that encompasses physical or mental conditions, or injuries, and that are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of a PACE participant or a provider of the service or medical supplies; and

(d) The most cost effective of the alternative levels of Medical services or medical supplies that can be safely provided to a PACE participant in the PACE program's judgment.

(28) Medicare — The federal health insurance program for the aged and disabled administered by the Health Care Financing Administration under Title XVIII of the Social Security Act.

(29) Non-Covered Services — Services or items the PACE program is not responsible for providing or paying for.

(30) Non-Participating Provider — A provider who does not have a contractual relationship with the PACE program, i.e., is not on their panel of providers.

(31) Division of Medical Assistance Programs (DMAP) — The division of the Department of Human Services responsible for coordinating medical assistance programs. DMAP writes and administers the state Medicaid rules for medical services, contracts with providers, maintains records of participant eligibility and processes and pays DMAP providers and contractors such as PACE.

(32) Addictions and Mental Health Division (AMH) — The division within the Oregon Health Authority responsible for the administration of the state's mental health and addiction services programs.

(33) Oregon Health Plan (OHP) — The Medicaid demonstration project that expands Medicaid eligibility. The Oregon Health Plan relies substantially upon a prioritization of health services and managed care to achieve the policy objectives of access, cost containment, efficacy and cost effectiveness in the allocation of health resources.

(34) PACE — The Program of all Inclusive Care for the Elderly (PACE) is a managed care entity that provides medical, dental, mental health, social services, transportation and long-term care services to persons age 55 and older on a prepaid capitated basis in accordance with a signed agreement with the Department and CMS.

(35) PACE Participant — An individual who meets the SPD criteria for nursing facility care and is enrolled in the PACE program. These individuals would be eligible under the following categories:

(a) AB/AD (Assistance to Blind and Disabled) with Medicare — Individuals with concurrent Medicare eligibility with income under current Medicaid eligibility rules;

(b) AB/AD without Medicare — Individuals without Medicare with income under current Medicaid eligibility rules;

(c) OAA (Old Age Assistance) with Medicare — Individuals with concurrent Medicare Part A or Medicare Parts A and B eligibility with income under current Medicaid eligibility rules;

(d) OAA without Medicare — Individuals without Medicare with income under current Medicaid eligibility rules; or

(e) Private — Individuals with or without Medicare with incomes over current Medicaid eligibility.

(36) Participating Provider — An individual, facility, corporate entity, or other organization that supplies medical, dental, or mental health services or items who have agreed to provide those services or items and to bill in accordance with a signed agreement with a PACE program.

(37) Preventive Services — Those services as defined under Expanded Definition of Preventive Services in OAR 410-141-0480 and 410-141-0520.

(38) Primary Care Provider (PCP) — A medical practitioner who has responsibility for supervising and coordinating initial and primary care within his or her scope of practice for PACE participants. Primary Care Providers initiate referrals for care outside their scope of practice that may include consultations and specialist care, and assure the continuity of medically or dentally appropriate care.

(39) Quality Improvement — Quality improvement is the effort to improve the level of performance of a key process or processes in health and long term care. A quality improvement program measures the level of current performance of the processes, finds ways to improve the performance and implements new and better methods for the processes. Quality Improvement includes the goals of quality assurance, quality control, quality planning and quality management in health care. Quality of care reflects the degree to which health services for individuals and populations increases the likelihood of desired health outcomes and is consistent with current professional knowledge.

(40) Representative — A person who can assist the PACE participant in making administrative related decisions such as, but not limited to, completing enrollment application, filing grievances, and requesting disenrollment. A representative may be, in the following order of priority, a person who is designated as the PACE participant's health care representative, a court-appointed guardian, a spouse, or other family member as designated by the PACE participant, the Individual Service Plan Team (for individuals with intellectual or developmental disabilities), a Department/AAA case manager or other Department designee. This definition does not apply to health care decisions unless the representative has legal authority to make such decisions.

(41) Service Area — The geographic area defined by Federal Information Processing Standards (FIPS) codes, or other criteria determined by the Department, in which the PACE program has agreed to provide services under the Oregon PACE program Regulations and the Federal PACE Regulations 42 CFR Part 460. This geographic area is defined in the PACE contract with the Department.

(42) Service Plan — An individualized, written plan that addresses all relevant aspects of a participant's health and socialization needs that is developed by the Interdisciplinary Team with the participant and the participant's representative involvement. It is based on the findings of the participant's assessments and defines specific service and treatment goals and objectives; proposed interventions; and the measurable outcomes to be achieved. It is reviewed at least every four months or as indicated by a

change in the participant's condition. The term "Service Plan" is synonymous with "Care Plan".

(43) Triage — Evaluations conducted to determine whether or not an emergency condition exists, and to direct the DMAP member to the most appropriate setting for medically appropriate care.

(44) Urgent Care Services — Covered services required to prevent a serious deterioration of a PACE participant's health that results from an unforeseen illness or an injury and for dental services necessary to treat such conditions as lost fillings or crowns. Services that can be foreseen by the individual are not considered urgent services.

(45) Valid Claim — An invoice received by the PACE program for payment of covered health care services rendered to an eligible PACE participant that:

(a) Can be processed without obtaining additional information from the provider of the service or from a third party;

(b) Has been received within the time limitations prescribed in these rules; and

(c) A "valid claim" is synonymous with the federal definition of a "clean claim" as defined in 42 CFR 447.45(b).

(46) Valid Pre-Authorization — A request, received by the PACE program for approval of covered health care services provided by a non-participating provider to an eligible individual, that can be processed without obtaining additional information from the provider of the service or from a third party.

Stat. Auth.: ORS 410.090
Stats. Implemented: ORS 410.070
Hist.: SDSD 5-2000, f. 12-29-00 cert. ef. 1-1-01; SPD 2-2005, f. & cert. ef. 1-4-05; SPD 14-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-045-0050
Enrollment

(1) ELIGIBILITY: To be eligible to enroll in a PACE program a person must:

(a) Reside in the PACE program's approved service area upon enrollment;

(b) Be 55 years of age or older;

(c) Be able to be maintained in a community-based setting at the time of enrollment without jeopardizing his or her health or safety or the health and safety of others;

(d) Be determined by the local Department/AAA agency to need the level of care required under Oregon's State Medicaid Plan for coverage of nursing facility services in accordance with OAR 411-015-0000–411-015-0100 Service Priority, Current Limitations and Eligibility for Nursing Facility or home and community-based waivered or state plan services;

(e) Be Medicaid eligible or be willing to pay private fees; and

(f) Be willing to abide by the provision that requires enrollees to receive all health and long term care services exclusively from the PACE program and its contracted or referred providers.

(2) The criteria for determining that an individual cannot live safely in the community and thereby may be denied enrollment is as follows:

(a) The individual demonstrates imminent danger to self or others in accordance with the definition in OAR 411-015-0005;

(b) There is evidence in the individual's clinical record that shows he or she has been repeatedly placed in appropriate care settings and, despite medically appropriate treatment, placement has resulted in frequent hospitalizations or failed placements; or

(c) At the time of application, the individual is determined to be eligible for enhanced care services or long term care at Oregon State Hospital by either the enhanced care Services Coordinator or the OSH Gero-Psychiatric Outreach Team.

(d) At the time of application, the individual has a physician documented condition that meets the criteria for Medicare skilled care and does not appear to be able to be discharged to the community within the next 30 days.

(e) At the time of application, the applicant lives in their own home and wishes to remain there but requires 24-hour care to remain safely in their home.

(3) If either the PACE program or the local Department/AAA case manager has concerns about the safety of a potential enrollee, a case conference can be convened to review the case with outside consultants as needed for further evaluation.

(4) Enrollment/Screening and Intake:

(a) Department/AAA staff will process the application for Medicaid services and determine the level of care required under Oregon's State Medicaid Plan for coverage of nursing facility services. Department/AAA staff will follow appropriate PACE enrollment protocols as outlined in the SPD/AAA Policy Manuals.

(b) Department/AAA staff will conduct initial screening and intake, including providing assistance in completing the application and obtaining relevant information.

(c) The Department will provide for the calculation of any applicable spend-down liability and for post-eligibility treatment of income for Medicaid participants in the same manner as the Department treats spend-down liability and post-eligibility income for individuals receiving home and community-based waivered or state plan services (OAR 461-160-0620).

(d) The Department/AAA staff will forward intake information of potential enrollees to the PACE program staff who will assess the applicant's appropriateness for enrollment in the PACE program in accordance with these rules and the requirements of 42 CFR 460.152. Potential enrollees may be denied enrollment by the PACE program if it determines the individual would not be able to be maintained in a community based setting without jeopardizing his or her health or safety or the health and safety of others.

(e) If the potential enrollee or his or her representative is in disagreement with the PACE program's decision not to enroll the person, he or she may file an appeal with the Department.

(f) All letters to applicants regarding denial of enrollment by the PACE program must include the reason for the denial and the applicants appeal rights. This letter along with documentation of pertinent information related to the decision must be forwarded to the Department for review.

Stat. Auth.: ORS 410.090
Stats. Implemented: ORS 410.070
Hist.: SDSD 5-2000, f. 12-29-00 cert. ef. 1-1-01; SPD 2-2005, f. & cert. ef. 1-4-05; SPD 14-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-048-0150
Purpose

(1) The rules in OAR chapter 411, division 048 establish standards and procedures for Medicaid enrolled providers who provide long term care community nursing services. Long term care community nursing services provide ongoing registered nurse (RN) services to eligible individuals who are receiving Medicaid funded home and community-based waivered or state plan services in a home based or foster home setting.

(2) Long term care community nursing services provide:

(a) Evaluation and identification of supports that help an individual maintain maximum functioning and minimize health risks, while promoting the individual's autonomy and self management of healthcare;

(b) Teaching an individual's caregiver or family that is necessary to assure the individual's health and safety in a home based or foster home setting;

(c) Delegation of nursing tasks to an individual's caregiver; and

(d) Case managers and health professionals with the information needed to maintain the individual's health, safety, and community living situation while honoring the individual's autonomy and choices.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SPD 8-2013, f. & cert. ef. 4-15-13; SPD 14-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-048-0160
Definitions

(1) "AAA" means the Area Agency on Aging designated by the Department that is responsible for providing a comprehensive and coordinated system of services to older adults or adults with disabilities in a designated planning and service area.

(2) "Abuse" means:

(a) Abuse of a child:

(A) As defined in ORS 419B.005; and

(B) As defined in OAR 407-045-0260, when a child resides in a foster home licensed by the Department to provide residential services to a child with developmental disabilities.

(b) Abuse of an adult or older adult:

(A) As defined in ORS 124.050-095 and 430.735-765; and

(B) As defined in OAR 407-045-0260 for individuals 18 years or older with developmental disabilities that reside in a Department licensed adult foster home; or

(C) As defined in OAR 411-020-0002 for older adults and adults with a physical disability who are 18 years of age or older that reside in a Department licensed adult foster home.

(3) "Acute Care Nursing" means, for the purpose of these rules, nursing services provided on an intermittent or time limited basis such as those

provided by a hospice agency as defined in ORS 443.850, or a home health agency as defined in 443.005. Acute care nursing may include direct service and is designed to address a specific task of nursing or a short term health condition.

(4) "Business Day" means the day that the "Local Office" is open for business.

(5) "Care Coordination" means the email, faxes, phone calls, meetings and other types of information exchange, consultation, and advocacy provided by a registered nurse on behalf of an individual that is necessary for the registered nurse to conduct assessments, complete medication reviews, provide for individual safety needs, and implement an individual's Nursing Service Plan.

(6) "Caregiver" means any person responsible for providing services to an eligible individual in a home based or foster home setting. For the purpose of these rules, a caregiver may include an unlicensed person defined as a designated caregiver in OAR chapter 851, division 48 (Standards for Provision of Nursing Care by a Designated Caregiver).

(7) "Case Manager" means a person employed by the Department, Community Developmental Disability Program, or Area Agency on Aging who assesses the service needs of an applicant, determines eligibility, and offers service choices to the eligible individual. The case manager authorizes and implements an individual's plan for services and monitors the services delivered.

(8) "CDDP" means the Community Developmental Disability Program responsible for the planning and delivery of services for individuals with developmental disabilities according to OAR chapter 411, division 320. A CDDP operates in a specific geographic service area of the state under a contract with the Department, local mental health authority, or other entity as contracted by the Department.

(9) "Delegation" means, for the purpose of these rules, the standards and processes described in OAR chapter 851, division 047 (Standards for Community Based Care Registered Nurse Delegation).

(10) "Department" means the Department of Human Services or the Department's designee.

(11) "Department Approved Form" means forms used by registered nurses and case managers to support these rules. The Department maintains these documents on the Department's website (http://www.oregon.gov/dhs/spd/pages/provtools/nursing/forms.aspx). Printed copies may be obtained by contacting the Department of Human Services, ATTN: Rule Coordinator, 500 Summer Street NE, E10, Salem, OR 97301.

(12) "Direct Hands-on Nursing" means a registered nurse provides treatment or therapies directly to an individual instead of teaching or delegating the tasks of nursing to the individual's caregiver. Payment for direct hands-on nursing services is not reimbursed unless an exception has been granted by the Department as described in OAR 411-048-0170.

(13) "Documentation" means a written record of all services provided to, and for, an individual and an individual's caregiver that is maintained by the registered nurse as described in OAR 411-048-0200.

(14) "Enrolled Medicaid Provider" means an entity or individual that meets and completes all the requirements in these rules, OAR 407-120-0300 to 0400 (Medicaid Provider Enrollment and Claiming), and chapter 410, division 120 (Medicaid General Rules) as applicable.

(15) "Foster Home" means any Department licensed or certified family home in which residential services are provided as described in:

(a) OAR chapter 411, division 050 for adult foster homes for older adults and adults with physical disabilities;

(b) OAR chapter 411, division 346 for foster homes for children with developmental disabilities; and

(c) OAR chapter 411, division 360 for adult foster homes for individuals with developmental disabilities.

(16) "Healthcare Provider" means a licensed provider providing services such as but not limited to home health, hospice, mental health, primary care, specialty care, durable medical equipment, pharmacy, or hospitalization to an eligible individual.

(17) "Home" means a non-licensed setting where an individual is receiving home and community-based waivered or state plan services.

(18) "Home Health Agency" has the meaning given that term in ORS 443.005.

(19) "Individual" means a person eligible for community nursing services under these rules.

(20) "In-Home Care Agency" has the meaning given that term in ORS 443.305.

(21) "Local Office" means the Department office, Area Agency on Aging, or Community Developmental Disability Program responsible for Medicaid services including case management, referral, authorization, and oversight of long term care community nursing services in the region where the individual lives and where the community nursing services are delivered.

(22) "Long Term Care Community Nursing Services (Community Nursing Service)" mean, for the purpose of these rules, the nursing services provided under these rules to individuals living in a home based or foster home setting where the monthly home and community-based waivered or state plan services rate does not include nursing services. Long term care community nursing services are a distinct set of services that focus on an individual's chronic and ongoing health and activity of daily living needs. Long term care community nursing services include an assessment, monitoring, delegation, teaching, and coordination of services that addresses an individual's health and safety needs in a Nursing Service Plan that supports individual choice and autonomy. The requirements in these rules are provided in addition to any nursing related requirements stipulated in the licensing rules governing the individual's place of residence.

(23) "Medication Review" means a review focused on an individual's medication regime that includes examination of the prescriber's orders and related administration records, consultation with a pharmacist or the prescriber, clarification of PRN (as needed) parameters, and the development of a teaching plan based upon the needs of the individual or the individual's caregiver. In an unlicensed setting, the medication review may include observation and teaching related to administration methods and storage systems.

(24) "Nursing Assessment" means one of the following assessments selected by the registered nurse based on an individual's need and situation:

(a) A "nursing assessment" as defined in OAR 851-047-0010 (Standards for Community Based Care Registered Nurse Delegation); or

(b) A "comprehensive assessment" or "focused assessment" as defined in OAR 851-045-0030 (Standards and Scope of Practice for the Licensed Practical Nurse and Registered Nurse).

(25) "Nursing Service Plan" means the plan that is developed by the registered nurse based on an individual's initial nursing assessment, reassessment, or updates made to a nursing assessment as a result of monitoring visits.

(a) The Nursing Service Plan is specific to the individual and identifies the individual's diagnoses and health needs, the caregiver's teaching needs, and any care coordination, teaching, or delegation activities.

(b) The Nursing Service Plan is separate from the case manager's service plan, the foster home provider's service plan, and any service plans developed by other health professionals.

(c) Nursing service plans must meet the standards in OAR chapter 851, division 045 (Standards and Scope of Practice for the Licensed Practical Nurse and Registered Nurse).

(26) "OSBN" means the Oregon State Board of Nursing. OSBN is the agency responsible for regulating nursing practice and education for the purpose of protecting the public's health, safety, and well-being.

(27) "Rate Schedule" means the communication tool issued by the Department to transmit rate changes to partners, subcontractors, and stakeholders. The Department maintains this document on the Department's website (http://www.oregon.gov/dhs/spd/provtools/rateschedule.pdf). Printed copies may be obtained by contacting the Department of Human Services, ATTN: Rule Coordinator, 500 Summer Street NE, E10, Salem, OR 97301.

(28) "RN" means a registered nurse licensed by the Oregon State Board of Nursing. An RN providing long term care community nursing services under these rules is either an independent contractor who is an enrolled Medicaid provider or an employee of an organization that is an enrolled Medicaid provider.

(29) "These Rules" mean the rules in OAR chapter 411, division 048.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SPD 8-2013, f. & cert. ef. 4-15-13; SPD 14-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-048-0170
Eligibility and Limitations

(1) ELIGIBILITY. Community nursing services may be provided by an RN to an individual if the individual meets the following requirements:

(a) The individual must be determined eligible for home and community-based waivered or state plan services provided through the Department;

(b) The individual must be receiving services through one of the following:

(A) Long term supports for children with developmental disabilities as described in OAR chapter 411, division 308;

(B) Adult foster homes for individuals with developmental disabilities as described in OAR chapter 411, division 360;

(C) Foster homes for children with developmental disabilities as described in OAR chapter 411, division 346;

(D) Comprehensive in home support for adults with developmental disabilities as described in OAR chapter 411, division 330;

(E) Adult foster homes for older adults and adults with physical disabilities as described in OAR chapter 411, division 050;

(F) Independent Choices Program participants as described in OAR chapter 411, division 030;

(G) 1915C Nursing Facility Waiver; or

(H) State Plan K Community First Choice;

(c) The individual must live in a home or a foster home as defined in OAR 411-048-0160;

(d) The individual must be referred by their case manager for long term care community nursing services. Individuals may request long term community nursing services through their case manager.

(2) LIMITATIONS.

(a) Long term care community nursing services may not be provided to:

(A) A resident of a nursing facility, assisted living facility, residential care facility, 24 hour developmental disability group home, or intermediate care facility for individuals with developmental disabilities;

(B) An individual enrolled in a brokerage, Independent Choices, or other support services not funded by home and community-based waivered or state plan services; or

(C) An individual enrolled in a program or residing in a setting where nursing services are provided under a monthly service rate.

(b) Case managers may not prior authorize long term care community nursing services that duplicate nursing services provided by Medicare or other Medicaid programs.

(c) Long term care community nursing services do not include nursing activities used for administrative functions such as protective service investigations, pre-admission screenings, eligibility determinations, licensing inspections, case manager assessments, or corrective action activities. This limitation does not include authorized care coordination as defined in OAR 411-048-0160.

(d) Long term care community nursing services do not include reimbursement for direct hands-on nursing as defined in OAR 411-048-0160.

(3) EXCEPTIONS. An exception to sections (2)(c) and (2)(d) of this rule may be requested as described in OAR 411-048-0250.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SPD 8-2013, f. & cert. ef. 4-15-13; SPD 14-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-065-0000
Purpose

The purpose of these rules is to establish standards for specialized living service contracts. The standards provide an enhanced continuum of quality care in a home-like environment for specific target groups who are eligible for a live-in attendant, but because of special needs, cannot live independently or be served in other community-based care facilities and who would otherwise require nursing facility care. Services provided to residents in the Specialized Living Services Program are those covered in Oregon's Home and Community-based Waiver or State Plan, which may include specific services required because of physical, intellectual or behavioral limitations in meeting self-care needs.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SSD 5-1982, f. 5-12-82, ef. 5-15-82; SSD 19-1991, f. & cert. ef. 10-10-91; SPD 14-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-070-0033
Post Hospital Extended Care Benefit

(1) The post hospital extended care benefit (OAR 410-120-1210(3)(a)(F)) is an Oregon Health Plan benefit that consists of a stay of up to 20 days in a nursing facility to allow discharge from hospitals.

(2) The post hospital extended care benefit must be prior authorized by pre-admission screening for individuals not enrolled in managed care.

(3) To be eligible for the post hospital extended care benefit, the individual must meet all of the following:

(a) Be receiving Oregon Health Plan Plus or Standard, Fee-for-Service benefits;

(b) Not be Medicare eligible;

(c) Have a medically-necessary, qualifying hospital stay consisting of:

(A) A DMAP-paid admission to an acute-care hospital bed, not including a hold bed, observation bed, or emergency room bed.

(B) The stay must consist of three or more consecutive days, not counting the day of discharge.

(d) Transfer to a nursing facility within 30 days of discharge from the hospital;

(e) Need skilled nursing or rehabilitation services on a daily basis for a hospitalized condition meeting Medicare skilled criteria that may be provided only in a nursing facility meaning:

(A) The individual would be at risk of further injury from falls, dehydration, or nutrition because of insufficient supervision or assistance at home;

(B) The individual's condition would require daily transportation to hospital or rehabilitation facility by ambulance; or

(C) It is too far to travel to provide daily nursing or rehabilitation services in the individual's home.

(4) The individual may qualify for another 20 day post-hospital extended care benefit only if the individual has been out of a hospital and has not received skilled nursing care for 60 consecutive days in a row and meets all the criteria in this rule.

(5) Individuals eligible for the 20 day post-hospital extended care benefit are not eligible for long term care nursing facility or home and community-based waivered or state plan services unless the individual meets the eligibility criteria in OAR 411-015-0100 or OAR 411-320-0020(28).

Stat. Auth.: ORS 409, 410.070 & 414.065
Stats. Implemented: 410.070 & 414.065
Hist.: SPD 4-2005, f. & cert. ef. 4-19-05; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09; SPD 14-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

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Rule Caption: Aging and People with Disabilities — Case Management Services
Adm. Order No.: SPD 15-2013(Temp)
Filed with Sec. of State: 7-1-2013
Certified to be Effective: 7-1-13 thru 12-28-13
Notice Publication Date:
Rules Adopted: 411-028-0000, 411-028-0010, 411-028-0020, 411-028-0030, 411-028-0040, 411-028-0050
Subject: The Department of Human Services (Department) is immediately adopting rules in OAR chapter 411, division 028 to ensure case management services support the independence, empowerment, dignity, and human potential of a Medicaid service recipient with the purpose of helping the service recipient reside in his or her own home or in a community-based setting.
Rules Coordinator: Christina Hartman—(503) 945-6398

411-028-0000
Purpose

(1) The rules in OAR chapter 411, division 028 ensure Title XIX waivered case management services support the independence, empowerment, dignity, and human potential of a Medicaid service recipient with the purpose of helping the Medicaid service recipient reside in his or her own home or in a community-based setting.

(2) Title XIX waivered case management services are a component of a Medicaid service recipient's comprehensive, person-centered plan for services.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SDP 15-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-028-0010
Definitions

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 028:

(1) "Case Management" means the functions described in OAR 411-028-0020 performed by a case manager, services coordinator, or manager. Case management includes determining service eligibility, developing a plan of authorized services, and monitoring the effectiveness of services and supports.

(2) "Case Manager" means a Department employee or an employee of the Department's designee that meets the minimum qualifications in OAR 411-028-0040 who is responsible for service eligibility, assessment of need, offering service choices to eligible individuals, service planning, service authorization and implementation, and evaluation of the effectiveness of home and community-based waivered or state plan services.

(3) "Collateral Contact" means contact by a case manager with others who may provide information regarding an individual's health, safety, functional needs, social needs, or effectiveness of the individual's plan for services. Collateral contact may include family members, service providers, medical providers, neighbors, pharmacy staff, friends, or other professionals involved in the service coordination of an individual receiving home and community-based waivered or state plan services.

(4) "Department" means the Department of Human Services.

(5) "Designee" means an organization that the Department contracts with or has an interagency agreement with for the purposes of providing case management services to individuals eligible for home and community-based waivered or state plan services.

(6) "Home and Community-Based Services" mean services approved for Oregon by the Centers for Medicare and Medicaid Services for older adults and individuals with physical disabilities in accordance with Sections 1915 (k), 1915 (j) and 1115 of Title XIX of the Social Security Act.

(7) "Individual" means a person applying or determined eligible for home and community-based waivered or state plan services.

(8) "OSIP-M" means Oregon Supplemental Income Program-Medical as defined in OAR 461-101-0010. OSIPM is Oregon Medicaid insurance coverage for individuals who meet eligibility criteria as described in OAR chapter 461.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SDP 15-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-028-0020
Scope of Case Management Services

(1) DIRECT CASE MANAGEMENT SERVICES. Direct case management services are provided by a case manager, adult protective services investigator, or higher level staff who communicates directly with an individual or the individual's representative. Direct case management services may occur by phone call, face-to-face contact, or email. Direct case management services do not include contact with collateral contacts unless the collateral contact is the individual's authorized representative. Direct case management services include:

(a) Assessment as described in OAR 411-015-0008;

(b) Service Plan development and review as described in OAR 411-015-0008;

(c) Service options choice counseling as described in OAR 411-030-0050;

(d) Risk assessment and monitoring:

(A) Identifying and documenting risks;

(B) Working with an individual to eliminate or reduce risks;

(C) Developing and implementing a Risk Mitigation Plan;

(D) Monitoring risks over time; and

(E) Making adjustments to an individual's Service Plan as needed.

(e) Diversion activities. Assisting an individual with finding alternatives to a nursing facility admission;

(f) Adult protective services investigation including all protective service activity directly provided to an individual;

(g) Other program coordination. Helping an individual navigate or coordinate with other social, health, and assistance programs;

(h) Crisis response and intervention. Assisting an individual with problem resolution; and

(i) Service provision issues. Assisting an individual with problem solving to resolve issues that occur with providers, services, or hours that don't meet the individual's needs.

(2) INDIRECT CASE MANAGEMENT SERVICES. Indirect case management services are services provided by a case manager, adult protective services investigator, or higher level staff in which direct contact with an individual is not occurring. Indirect case management services include --

(a) Monitoring Service Plan implementation. Reviewing implementation of an individual's Service Plan by reviewing and comparing authorized and billed services to ensure that adequate services are being provided;

(b) Service options choice counseling. Assisting an individual's caregiver, family member, or other support person with understanding all available home and community-based waivered or state plan service options;

(c) Risk monitoring. Working with a collateral contact to review an individual's risks, eliminating or reducing risks, and developing and implementing a Risk Mitigation Plan. Adjustments to an individual's Service Plan based on risk monitoring activities are classified as direct case management;

(d) Diversion activities. Finding alternatives to a nursing facility admission. Diversion activities do not include transition activities to help an individual move from a nursing facility.

(e) Adult protective services referral including collateral contact and investigative work;

(f) Other program coordination. Helping collateral contacts navigate or coordinate with other social, health, and assistance programs;

(g) Service provision issues. Assisting with problem solving issues that occur with providers, services, or hours that do not meet an individual's needs; and

(h) Other case management activities not included in any criteria in this section of the rule.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SDP 15-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-028-0030
Eligibility for Case Management Services

To be eligible for waivered case management services an individual must:

(1) Be 18 years of age or older;

(2) Be eligible for OSIP-M; and

(3) Meet the functional impairment level within the service priority levels currently served by the Department as outlined in OAR 411-015-0010 and 411-015-0015.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SDP 15-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-028-0040
Qualified Case Manager

Staff working for the Department or the Department's designee must meet the following requirements to provide case management services:

(1) A bachelor's degree in a behavioral science, social science, or a closely related field; or

(2) A bachelor's degree in any field and one year of human services related experience that may include providing assistance to people and groups with issues such as economical disadvantages, employment barriers and shortages, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or inadequate housing; or

(3) An associate's degree in a behavioral science, social science or a closely related field AND two years of human services related experience that may include providing assistance to people and groups with issues such as economical disadvantages, employment barriers and shortages, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or inadequate housing; or

(4) Three years of human services related experience that may include providing assistance to people and groups with issues such as economical disadvantages, employment barriers and shortages, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or inadequate housing.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SDP 15-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-028-0050
Frequency of Case Management Services

A case manager who meets the requirements in OAR 411-028-0040 must provide the following case management services to an eligible individual receiving home and community-based waivered or state plan services no less than one time every calendar month:

(1) A direct case management service as described in OAR 411-028-0020 must be provided to an eligible individual no less than once in each calendar quarter.

(2) An indirect case management service must be provided in every calendar month a direct case management service was not provided.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070
Hist.: SDP 15-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

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Rule Caption: Medicaid In-Home Services — Home and Community-Based Waivered and State Plan Services
Adm. Order No.: SPD 16-2013(Temp)
Filed with Sec. of State: 7-1-2013
Certified to be Effective: 7-1-13 thru 11-19-13
Notice Publication Date:
Rules Amended: 411-030-0020

Rules Suspended: 411-030-0020(T)
Subject: The Department of Human Services (Department) is immediately amending OAR 411-030-0020 to be in compliance with new Medicaid authority to provide both home and community-based waivered and state plan services.
Rules Coordinator: Christina Hartman—(503) 945-6398

411-030-0020
Definitions

As used in these rules:

(1) "AAA" means "Area Agency on Aging" as defined in this rule.

(2) "Activities of Daily Living (ADL)" mean those personal, functional activities required by an individual for continued well-being, which are essential for health and safety. Activities include eating, dressing/grooming, bathing/personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel, and bladder management), and cognition/behavior as defined in OAR 411-015-0006.

(3) "ADL" means "activities of daily living" as defined in this rule.

(4) "Architectural Modifications" means any service leading to the alteration of the structure of a dwelling to meet a specific service need of an eligible individual.

(5) "Area Agency on Aging (AAA)" means the Department designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to older adults or individuals with disabilities in a planning and service area. For purposes of these rules, the term Area Agency on Aging is inclusive of both Type A and Type B Area Agencies on Aging as defined in ORS 410.040 and described in ORS 410.210 to 410.300.

(6) "Assistive Devices" means any category of durable medical equipment, mechanical apparatus, electrical appliance, or instrument of technology used to assist and enhance an individual's independence in performing any activity of daily living. Assistive devices include the use of service animals, general household items, or furniture to assist the individual.

(7) "Business Days" means Monday through Friday and excludes Saturdays, Sundays, and state or federal holidays.

(8) "CA/PS" means the "Client Assessment and Planning System" as defined in this rule.

(9) "Case Manager" means an employee of the Department or Area Agency on Aging who assesses the service needs of an applicant, determines eligibility, and offers service choices to the eligible individual. The case manager authorizes and implements the service plan, and monitors the services delivered.

(10) "Client Assessment and Planning System (CA/PS)" is a single entry data system used for completing a comprehensive and holistic assessment, surveying the individual's physical, mental, and social functioning, and identifying risk factors, individual choices, and preferences, and the status of service needs. The CA/PS documents the level of need and calculates the individual's service priority level in accordance with the rules in OAR chapter 411, division 015, calculates the service payment rates, and accommodates individual participation in service planning.

(11) "Collective Bargaining Agreement" means the ratified Collective Bargaining Agreement between the Home Care Commission and the Service Employee's International Union, Local 503, Oregon Public Employees' Union. The Collective Bargaining Agreement is maintained on the Department's website: (http://www.oregon.gov/dhs/spd/adv/hcc/docs/contract1113.pdf). Printed copies may be obtained by contacting the Department of Human Services, Aging and People with Disabilities, ATTN: Rule Coordinator, 500 Summer Street NE, E-10, Salem, Oregon 97301.

(12) "Consumer" or "Consumer-Employer" means the individual eligible for in-home services. "Consumer" is synonymous with client and individual.

(13) "Consumer-Employed Provider Program" refers to the program wherein the provider is directly employed by the consumer to provide either hourly or live-in services. In some aspects of the employer and employee relationship, the Department acts as an agent for the consumer-employer. These functions are clearly described in OAR 411-031-0040.

(14) "Contingency Fund" means a monetary amount set aside in the Independent Choices Program service budget that continues month to month if approved by the case manager, to purchase identified items that substitute for personal assistance.

(15) "Contracted In-Home Care Agency" means an incorporated entity or equivalent, licensed in accordance with OAR chapter 333, division 536 that provides hourly contracted in-home services to individuals served by the Department or Area Agency on Aging.

(16) "Cost Effective" means being responsible and accountable with Department resources. This is accomplished by offering less costly alternatives when providing choices that adequately meet an individual's service needs. Those choices include other programs available from the Department, the utilization of assistive devices, natural supports, architectural modifications, and alternative service resources (defined in OAR 411-015-0005). Less costly alternatives may include resources not paid for by the Department.

(17) "Department" means the Department of Human Services (DHS). "Department" is synonymous with Seniors and People with Disabilities Division (SPD).

(18) "Discretionary Fund" means a monetary amount set aside in the Independent Choices Program service budget to purchase items not otherwise delineated in the monthly service budget or agreed to be savings for items not traditionally covered under home and community-based waivered or state plan services. Discretionary funds must be expended at the end of each month.

(19) "Disenrollment" means either voluntary or involuntary termination of the participant from the Independent Choices Program.

(20) "DMAP" means the Oregon Health Authority, Division of Medical Assistance Programs.

(21) "Employee Provider" means a worker who provides services to, and is a paid provider for, a participant in the Independent Choices Program.

(22) "Employment Relationship" means the relationship involving the employee provider and the participant as employee and employer.

(23) "Exception" means an approval for payment of a service plan granted to a specific individual in their current residence or in the proposed residence identified in the exception request that exceeds the CA/PS assessed service payment levels for individuals residing in community-based care facilities or the maximum hours of service as described in OAR 411-030-0070 for individuals residing in their own homes or the home of a relative. The approval is based on the service needs of the individual and is contingent upon the service plan meeting the requirements in 411-027-0020, 411-027-0025, and 411-027-0050. The term "exception" is synonymous with "exceptional rate" or "exceptional payment."

(24) "FICA" is the acronym for the Social Security payroll taxes collected under authority of the Federal Insurance Contributions Act.

(25) "Financial Accountability" refers to guidance and oversight which act as fiscal safeguards to identify budget problems on a timely basis and allow corrective action to be taken to protect the health and welfare of individuals.

(26) "FUTA" is the acronym for Federal Unemployment Tax Assessment which is a United States payroll (or employment) tax imposed by the federal government on both employees and employers.

(27) "Homecare Worker" means a provider, as described in OAR 411-031-0040, that is directly employed by a consumer to provide either hourly or live-in services to the eligible consumer.

(a) The term homecare worker includes consumer-employed providers in the Spousal Pay and Oregon Project Independence Programs. The term homecare worker also includes consumer-employed providers that provide state plan personal care services to older adults and individuals with physical disabilities. Relatives providing home and community-based waivered or state plan services to an individual living in the relative's home are considered homecare workers.

(b) Homecare worker does not include Independent Choices Program providers or personal support workers enrolled through Developmental Disability Services or the Addictions and Mental Health Division.

(28) "Hourly Services" mean the in-home services, including activities of daily living and instrumental activities of daily living, that are provided at regularly scheduled times.

(29) "IADL" means "instrumental activities of daily living" as defined in this rule.

(30) "ICP" means "Independent Choices Program" as defined in this rule.

(31) "Independent Choices Program (ICP)" means a self directed in-home services program in which the participant is given a cash benefit to purchase goods and services identified in a service plan and prior approved by the Department or Area Agency on Aging.

(32) "Individual" means the person applying for or eligible for services. The term "individual" is synonymous with "client", "participant", "consumer", and "consumer-employer".

(33) "Individualized Back-Up Plan" means a plan incorporated into the Independent Choices Program service plan to address critical contingencies or incidents that pose a risk or harm to the participant's health and welfare.

(34) "In-Home Services" mean those activities of daily living and instrumental activities of daily living that assist an individual to stay in his or her own home or the home of a relative.

(35) "Instrumental Activities of Daily Living (IADL)" mean those activities, other than activities of daily living, required by an individual to continue independent living. The definitions and parameters for assessing needs in IADL are identified in OAR 411-015-0007.

(36) "Liability" refers to the dollar amount individuals with excess income must contribute to the cost of service pursuant to OAR 461-160-0610 and 461-160-0620.

(37) "Live-In Services" mean the in-home services provided when an individual requires activities of daily living, instrumental activities of daily living, and twenty-four hour availability. Time spent by any live-in employee doing instrumental activities of daily living and twenty-four hour availability are exempt from federal and state minimum wage and overtime requirements.

(38) "Natural Supports" or "Natural Support System" means the resources available to an individual from their relatives, friends, significant others, neighbors, roommates, and the community. Services provided by natural supports are resources that are not paid for by the Department.

(39) "Oregon Project Independence (OPI)" means the program of in-home services described in OAR chapter 411, division 032.

(40) "Participant" means an individual eligible for the Independent Choices Program.

(41) "Provider" means the individual who actually renders the service.

(42) "Rate Schedule" means the rate schedule maintained by the Department at http://www.oregon.gov/DHS/spd/provtools/rateschedule.pdf. Printed copies may be obtained by contacting the Department of Human Services, Aging and People with Disabilities, ATTN: Rule Coordinator, 500 Summer Street NE, E-10, Salem, Oregon 97301.

(43) "Relative" means a person, who is related to an individual by blood, marriage, or adoption, excluding the individual's spouse,

(44) "Representative" is a person either appointed by an individual to participate in service planning on the individual's behalf or an individual's natural support with longstanding involvement in assuring the individual's health, safety, and welfare. There are additional responsibilities for the Independent Choices Program (ICP) representatives as described in OAR 411-030-0100. An ICP representative is not a paid employee provider regardless of relationship to the participant.

(45) "Service Budget" means the participant's plan for the distribution of authorized funds that are under the control and direction of the participant within the Independent Choices Program. The service budget is a required component of the service plan.

(46) "Service Need" means the assistance an individual requires from another person for those functions or activities identified in OAR 411-015-0006 and 411-015-0007.

(47) "SUTA" is the acronym for State Unemployment Tax Assessment. State unemployment taxes are paid by employers to finance the unemployment benefit system that exists in each state.

(48) "These Rules" mean the rules in OAR chapter 411, division 030.

(49) "Twenty-Four Hour Availability" means the availability and responsibility of a homecare worker to meet activities of daily living and instrumental activities of daily living of a consumer as required by that consumer over a twenty-four hour period. Twenty-four hour availability services are provided by a live-in homecare worker and are exempt from federal and state minimum wage and overtime requirements.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070
Hist.: SSD 5-1983, f. 6-7-83, ef. 7-1-83; SSD 3-1985, f. & ef. 4-1-85; SSD 5-1987, f. & ef. 7-1-87; SSD 4-1993, f. 4-30-93, cert. ef. 6-1-93; SSD 6-1994, f. & cert. ef. 11-15-94; SPD 14-2003, f. & cert. ef. 7-31-03; SPD 15-2003 f. & cert. ef. 9-30-03; SPD 18-2003(Temp), f. & cert. ef. 12-11-03 thru 6-7-04; SPD 15-2004, f. 5-28-04, cert. ef. 6-7-04; SPD 18-2005(Temp), f. 12-20-05, cert. ef. 12-21-05 thru 6-1-06; SPD 20-2006, f. 5-26-06, cert. ef. 6-1-06; SPD 3-2007(Temp), f. 4-11-07, cert. ef. 5-1-07 thru 10-28-07; SPD 17-2007, f. 10-26-07, cert. ef. 10-28-07; SPD 4-2008(Temp), f. & cert. ef. 4-1-08 thru 9-24-08; SPD 13-2008, f. & cert. ef. 9-24-08; SPD 15-2008, f. 12-26-08, cert. ef. 1-1-09; SPD 10-2013(Temp), f. & cert. ef. 5-23-13 thru 11-19-13; SDP 16-2013(Temp), f. & cert. ef. 7-1-13 thru 11-19-13

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Rule Caption: Pediatric Nursing Facilities
Adm. Order No.: SPD 17-2013(Temp)
Filed with Sec. of State: 7-1-2013
Certified to be Effective: 7-1-13 thru 12-28-13
Notice Publication Date:
Rules Amended: 411-070-0452
Subject: The Department of Human Services (Department) is immediately amending OAR 411-070-0452 to update the rebase relationship percentage that determines the rate for pediatric nursing facilities. The rebase relationship percentage is being updated on July 1, 2013 to 93% to more accurately reflect the cost of services for pediatric residents.
Rules Coordinator: Christina Hartman—(503) 945-6398

411-070-0452
Pediatric Nursing Facilities

(1) PEDIATRIC NURSING FACILITY.

(a) A pediatric nursing facility is a licensed nursing facility at least 50 percent of whose residents entered the facility before the age of 14 and all of whose residents are under the age of 21.

(b) A nursing facility that meets the criteria of subsection (1)(a) of this section is reimbursed as follows:

(A) The pediatric rate is a prospective rate and is not subject to settlement. The Department uses financial reports of facilities that have been in operation for at least 180 days and are in operation as of June 30 of even numbered years for biennial rebasing.

(B) The facility specific pediatric cost per resident day is inflated by the annual change in the DRI Index as measured in the previous 4th quarter. The Oregon Medicaid pediatric days are multiplied by the inflated facility specific cost per resident day for each pediatric facility. The totals are summed and divided by total Oregon Medicaid days to establish the weighted average cost per pediatric resident day. The rebase relationship percentage of 93 percent is applied to the weighted average cost to determine the pediatric rate.

(C) On July 1 of each non-rebasing year after 1999, the pediatric rate is increased by the annual change in the DRI Index, as measured in the previous 4th quarter. Beginning in 2001 rate rebasing occurs in alternate years. Rebasing of pediatric nursing facility rates is calculated using the method described in subsection (1)(b)(B) of this section.

(c) Even though pediatric facilities are reimbursed in accordance with subsection (1)(b) of this section, pediatric facilities must comply with all requirements relating to the timely submission of Nursing Facility Financial Statements.

(2) LICENSED NURSING FACILITY WITH A SELF-CONTAINED PEDIATRIC UNIT.

(a) A nursing facility with a self-contained pediatric unit is a licensed nursing facility that provides services for pediatric residents (individuals under the age of 21) in a separate and distinct unit within or attached to the facility with staffing costs separate and distinct from the rest of the nursing facility. All space within the pediatric unit must be used primarily for purposes related to the services of pediatric residents and alternate uses must not interfere with the primary use.

(b) A nursing facility that meets the criteria of subsection (2)(a) of this section is reimbursed for pediatric residents served in the pediatric unit as described in section (1) of this rule.

(c) Licensed nursing facilities with a self-contained pediatric unit must comply with all requirements relating to the timely submission of Nursing Facility Financial Statements and must file a separate attachment, on forms prescribed by the Department, related to the costs of the self-contained pediatric unit.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070 & 2011 OL Ch. 630
Hist.: SSD 4-1988, f. & cert. ef. 6-1-88; SSD 8-1991, f. & cert. ef. 4-1-91; SSD 14-1991(Temp), f. 6-28-91, cert. ef. 7-1-91; SSD 18-1991, f. 9-27-91, cert. ef. 10-1-91; SSD 6-1993, f. 6-30-93, cert. ef. 7-1-93; SSD 6-1995, f. 6-30-95, cert. ef. 7-1-95; SSD 6-1996, f. & cert. ef. 7-1-96; SDSD 10-1999, f.11-30-99, cert.ef. 12-1-99; SPD 9-2006, f. 1-26-06, cert. ef. 2-1-06; SPD 15-2007(Temp), f. & cert. ef. 9-10-07 thru 3-8-08; SPD 2-2008, f. 2-29-08, cert. ef. 3-1-08; SPD 15-2009, f. 11-30-09, cert. ef. 12-1-09; SPD 17-2011(Temp), f. & cert. ef. 7-1-11 thru 12-28-11; SPD 22-2011, f. 10-7-11, cert. ef. 11-1-11; SPD 10-2012, f. 7-31-12, cert. ef. 8-1-12; SDP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

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Rule Caption: Homecare Workers Enrolled in the Consumer-Employed Provider Program — Fiscal Improprieties
Adm. Order No.: SPD 18-2013(Temp)
Filed with Sec. of State: 7-1-2013
Certified to be Effective: 7-1-13 thru 12-28-13
Notice Publication Date:
Rules Amended: 411-031-0020, 411-031-0040

Subject: The Department of Human Services (Department) is temporarily amending the rules in OAR chapter 411, division 031 relating to homecare workers enrolled in the Consumer-Employed Provider Program to:

Immediately amend the definition of fiscal improprieties to protect a homecare worker employed by a relative from an allegation of fiscal improprieties; and

Comply with new Medicaid authority to provide both home and community-based waivered and state plan services.

Rules Coordinator: Christina Hartman—(503) 945-6398

411-031-0020
Definitions

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 031:

(1) "AAA" means "Area Agency on Aging" as defined in this rule.

(2) "Activities of Daily Living (ADL)" mean those personal, functional activities required by a consumer for continued well-being, which are essential for the consumer's health and safety. Activities include eating, dressing/grooming, bathing/personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel, and bladder management), and cognition/behavior as defined in OAR 411-015-0006.

(3) "ADL" means "activities of daily living" as defined in this rule.

(4) "Adult Protective Services" mean the services described in OAR chapter 411, division 020, OAR chapter 407, division 045, and OAR chapter 943, division 045 provided in response to the need for protection from harm or neglect to a consumer 18 years of age or older regardless of income.

(5) "Area Agency on Aging (AAA)" means the Department designated Area Agency on Aging (AAA) charged with the responsibility to provide a comprehensive and coordinated system of services to older adults or individuals with physical disabilities in a planning and service area. The terms AAA and Area Agency on Aging are inclusive of both Type A and Type B Area Agencies on Aging as defined in ORS 410.040 and described in ORS 410.210 to 410.300.

(6) "Burden of Proof" means the existence or nonexistence of a fact is established by a preponderance of evidence.

(7) "Career Homecare Worker" means a homecare worker with an unrestricted provider enrollment. A career homecare worker has a provider enrollment that allows the homecare worker to provide services to any eligible in-home services consumer. At any given time, a career homecare worker may choose not to be referred for work.

(8) "Case Manager" means an employee of the Department or Area Agency on Aging who assesses the service needs of an individual applying for services, determines eligibility, and offers service choices to the eligible individual. The case manager authorizes and implements an individual's service plan and monitors the services delivered.

(9) "CEP" means "Consumer-Employed Provider Program" as defined in this rule.

(10) "Collective Bargaining Agreement" means the ratified Collective Bargaining Agreement between the Home Care Commission and the Service Employee's International Union, Local 503, Oregon Public Employees' Union. The Collective Bargaining Agreement is maintained on the Department's website: (http://www.oregon.gov/dhs/spd/adv/hcc/docs/contract1113.pdf). Printed copies may be obtained by contacting the Department of Human Services, Aging and People with Disabilities, ATTN: Rules Coordinator, 500 Summer Street NE, E-10, Salem, Oregon 97301.

(11) "Companionship Services" mean those services designated by the Department of Labor as meeting the personal needs of a consumer. Companionship services are exempt from federal and state minimum wage laws.

(12) "Consumer" or "Consumer-Employer" means an older adult or an individual with a physical disability eligible for in-home services.

(13) "Consumer-Employed Provider Program (CEP)" refers to the program wherein a provider is directly employed by a consumer to provide either hourly or live-in services. In some aspects of the employer and employee relationship, the Department acts as an agent for the consumer-employer. These functions are clearly described in OAR 411-031-0040.

(14) "Department" means the Department of Human Services.

(15) "Evidence" means testimony, writings, material objects, or other things presented to the senses that are offered to prove the existence or nonexistence of a fact.

(16) "Fiscal Improprieties" means a homecare worker committed financial misconduct involving a consumer's money, property, or benefits.

(a) Fiscal improprieties include but are not limited to financial exploitation, borrowing money from the consumer, taking the consumer's property or money, having the consumer purchase items for the homecare worker, forging the consumer's signature, falsifying payment records, claiming payment for hours not worked, or similar acts intentionally committed for financial gain.

(b) Fiscal improprieties do not include the exchange of money, gifts, or property between a homecare worker and the consumer-employer with whom they are related unless an allegation of financial exploitation, as defined in OAR 411-020-0002 or 407-045-0260, has been substantiated based on an adult protective services investigation.

(17) "HCW" means "Homecare Worker" as defined in this rule.

(18) "Homecare Worker" means a provider, as described in OAR 411-031-0040, that is directly employed by an eligible consumer to provide either hourly or live-in services to the consumer.

(a) The term homecare worker includes:

(A) A consumer-employed provider in the Spousal Pay and Oregon Project Independence Programs;

(B) A consumer-employed provider that provides state plan personal care services to older adults and individuals with physical disabilities; and

(C) A relative providing in-home services to a consumer living in the relative's home.

(b) The term homecare worker does not include an Independent Choices Program provider or a personal support worker enrolled through Developmental Disability Services or the Addictions and Mental Health Division.

(19) "Hourly Services" mean the in-home services, including activities of daily living and instrumental activities of daily living, that are provided to a consumer at regularly scheduled times.

(20) "IADL" means "instrumental activities of daily living" as defined in this rule.

(21) "Imminent Danger" means there is reasonable cause to believe a consumer's life or physical, emotional, or financial well-being is in danger if no intervention is immediately initiated.

(22) "In-Home Services" mean those activities of daily living and instrumental activities of daily living that assist a consumer to stay in his or her own home.

(23) "Instrumental Activities of Daily Living (IADL)" mean those activities, other than activities of daily living, required by a consumer to continue independent living. The definitions and parameters for assessing a consumer's needs in IADL are identified in OAR 411-015-0007.

(24) "Lack of Ability or Willingness to Maintain Consumer-Employer Confidentiality" means a homecare worker is unable or unwilling to keep personal information about a consumer-employer private.

(25) "Lack of Skills, Knowledge, and Ability to Adequately or Safely Perform the Required Work" means a homecare worker does not possess the skills to perform services needed by consumers of the Department. The homecare worker may not be physically, mentally, or emotionally capable of providing services to consumers. The homecare worker's lack of skills may put consumers at risk because the homecare worker fails to perform, or learn to perform, the duties needed to adequately meet the needs of the consumers.

(26) "Live-In Services" mean those Consumer-Employed Provider Program services provided when a consumer requires activities of daily living, instrumental activities of daily living, and twenty-four hour availability. Time spent by any live-in homecare worker doing self-management and twenty-four hour availability are exempt from federal and state minimum wage and overtime requirements.

(27) "Office of Administrative Hearings" means the panel described in ORS 183.605 to 183.690 established within the Employment Department to conduct contested case proceedings and other such duties on behalf of designated state agencies.

(28) "OPI" means the Oregon Project Independence program of in-home services described in OAR chapter 411, division 032.

(29) "Preponderance of the Evidence" means that one party's evidence is more convincing than the other party's.

(30) "Provider" means an individual who actually renders in-home services.

(31) "Provider Enrollment" means a homecare worker's authorization to work as a provider employed by a consumer for the purpose of receiving payment for authorized services provided to consumers of the Department. Provider enrollment includes the issuance of a provider number.

(32) "Provider Number" means an identifying number issued to each homecare worker who is enrolled as a provider through the Department.

(33) "Relative" means an individual, who is related to a consumer by blood, marriage, or adoption, excluding the individual's spouse.

(34) "Restricted Homecare Worker" means the Department or Area Agency on Aging has placed restrictions on a homecare worker's provider enrollment as described in OAR 411-031-0040.

(35) "Self-Management Tasks" mean "instrumental activities of daily living" as defined in this rule.

(36) "Services are not Provided as Required" means a homecare worker does not provide services to a consumer as described in the consumer's service plan authorized by the Department.

(37) "These Rules" mean the rules in OAR chapter 411, division 031.

(38) "Twenty-Four Hour Availability" means the availability and responsibility of a homecare worker to meet activities of daily living and self-management needs of a consumer as required by the consumer over a twenty-four hour period. Twenty-four hour services are provided by a live-in homecare worker and are exempt from federal and state minimum wage and overtime requirements.

(39) "Unacceptable Background Check" means a check that produces information related to an individual's background that precludes the individual from being a homecare worker for the following reasons:

(a) The individual applying to be a homecare worker has been disqualified under OAR 407-007-0275;

(b) A homecare worker enrolled in the Consumer-Employed Provider Program for the first time, or after any break in enrollment, after July 28, 2009 has been disqualified under OAR 407-007-0275; or

(c) A background check and fitness determination has been conducted resulting in a "denied" status, as defined in OAR 407-007-0210.

(40) "Unacceptable Conduct at Work" means a homecare worker has repeatedly engaged in one or more of the following behaviors:

(a) Delay in arrival to work or absence from work not prior-scheduled with a consumer, that is either unsatisfactory to a consumer or neglect a consumer's service needs; or

(b) Inviting unwelcome guests or pets into a consumer's home, resulting in the consumer's dissatisfaction or a homecare worker's inattention to the consumer's required service needs.

(41) "Violation of a Drug-Free Workplace" means there was a substantiated complaint against a homecare worker for:

(a) Being intoxicated by alcohol, inhalants, prescription drugs, or other drugs, including over-the-counter medications, while responsible for the care of a consumer, while in the consumer's home, or while transporting the consumer; or

(b) Manufacturing, possessing, selling, offering to sell, trading, or using illegal drugs while providing authorized services to a consumer or while in the consumer's home.

(42) "Violation of Protective Service and Abuse Rules" means based on a substantiated allegation of abuse, a homecare worker was found to have violated the protective service and abuse rules described in OAR chapter 411, division 020, OAR chapter 407, division 045, or OAR chapter 943, division 045.

Stat. Auth.: ORS 409.050, 410.070 & 410.090

Stats. Implemented: ORS 410.010, 410.020 & 410.070

Hist.: SPD 17-2004, f. 5-28-04, cert.ef. 6-1-04; SPD 40-2004(Temp), f. 12-30-04, cert. ef. 1-1-05 thru 6-30-05; SPD 10-2005, f. & cert. ef. 7-1-05; SPD 15-2005(Temp), f. & cert. ef. 11-16-05 thru 5-15-06; SPD 15-2006, f. 4-26-06, cert. ef. 5-1-06; SPD 28-2006(Temp), f. 10-18-06, cert. ef. 10-23-06 thru 4-20-07; SPD 4-2007, f. 4-12-07, cert. ef. 4-17-07; SPD 3-2010, f. 5-26-10, cert. ef. 5-30-10; SPD 4-2010(Temp), f. 6-23-10, cert. ef. 7-1-10 thru 12-28-10; SPD 26-2010, f. 11-29-10, cert. ef. 12-1-10; SPD 13-2012(Temp), f. & cert. ef. 9-26-12 thru 3-25-13; SPD 4-2013, f. 3-25-13, cert. ef. 3-26-13; SDP 18-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-031-0040

Consumer-Employed Provider Program

The Consumer-Employed Provider Program contains systems and payment structures to employ both hourly and live-in providers. The live-in structure assumes a provider is required for activities of daily living (ADLs), instrumental activities of daily living (IADLs), and twenty-four hour availability. The hourly structure assumes a provider is required for ADLs and IADLs during specific substantial periods. Except as indicated, all of the following criteria apply to both hourly and live-in providers:

(1) EMPLOYMENT RELATIONSHIP. The relationship between a provider and a consumer is that of employee and employer.

(2) CONSUMER-EMPLOYER JOB DESCRIPTIONS. A consumer-employer is responsible for creating and maintaining a job description for a potential provider in coordination with the services authorized by the consumer's case manager.

(3) HOMECARE WORKER LIABILITIES. The only benefits available to homecare workers are those negotiated in the Collective Bargaining Agreement and as provided in Oregon Revised Statute. This Agreement does not include participation in the Public Employees Retirement System or the Oregon Public Service Retirement Plan. Homecare workers are not state employees.

(4) CONSUMER-EMPLOYER ABSENCES. When a consumer-employer is absent from his or her home due to an illness or medical treatment and is expected to return to the home within a 30 day period, the consumer's live-in provider may be retained to ensure the live-in provider's presence upon the consumer's return or to maintain the consumer's home for up to 30 days at the rate of pay immediately preceding the consumer's absence.

(5) SELECTION OF HOMECARE WORKER. A consumer-employer carries primary responsibility for locating, interviewing, screening, and hiring his or her own employees. The consumer-employer has the right to employ any individual who successfully meets the provider enrollment standards described in section (8) of this rule. The Department/AAA office determines whether a potential homecare worker meets the enrollment standards needed to provide services authorized and paid for by the Department.

(6) EMPLOYMENT AGREEMENT. A consumer-employer retains the full right to establish an employer-employee relationship with an individual at any time after the individual's Bureau of Citizenship and Immigration Services papers have been completed and identification photocopied. Payment for services is not guaranteed until the Department has verified that an individual meets the provider enrollment standards described in section (8) of this rule and notified both the employer and homecare worker in writing that payment by the Department is authorized.

(7) TERMS OF EMPLOYMENT. A consumer-employer must establish terms of an employment relationship with an employee at the time of hire. The terms of employment may include dismissal or resignation notice, work scheduling, absence reporting, and any sleeping arrangements or meals provided for live-in or hourly employees. Termination and the grounds for termination of employment are determined by a consumer-employer. A consumer-employer has the right to terminate an employment relationship with a homecare worker at any time and for any reason.

(8) PROVIDER ENROLLMENT.

(a) ENROLLMENT STANDARDS. A homecare worker must meet all of the following standards to be enrolled with the Department's Consumer-Employed Provider Program:

(A) The homecare worker must maintain a drug-free work place.

(B) The homecare worker must complete the background check process described in OAR 407-007-0200 to 407-007-0370 with an outcome of approved or approved with restrictions. The Department/AAA may allow a homecare worker to work on a preliminary basis in accordance with OAR 407-007-0315 if the homecare worker meets the other provider enrollment standards described in this section of the rule.

(C) The homecare worker must have the skills, knowledge, and ability to perform, or to learn to perform, the required work.

(D) The homecare worker's U.S. employment authorization must be verified.

(E) The homecare worker must be 18 years of age or older. The Department may approve a restricted enrollment, as described in section (8)(d) of this rule, for a homecare worker who is at least 16 years of age.

(F) The homecare worker must complete an orientation as described in section (8)(e) of this rule.

(G) The homecare worker must have a tax identification number or social security number that matches the homecare worker's legal name, as verified by the Internal Revenue Service or Social Security Administration.

(b) The Department/AAA may deny an application for provider enrollment in the Consumer-Employed Provider Program when:

(A) The applicant has a history of violating protective service and abuse rules;

(B) The applicant has committed fiscal improprieties;

(C) The applicant does not have the skills, knowledge, or ability to adequately or safely provide services;

(D) The applicant has an unacceptable background check;

(E) The applicant is not 18 years of age;

(F) The applicant has been excluded by the Health and Human Services, Office of Inspector General, from participation in Medicaid, Medicare, and all other Federal Health Care Programs;

(G) The Department/AAA has information that enrolling the applicant as a homecare worker may put vulnerable consumers at risk; or

(H) The applicant's tax identification number or social security number does not match the applicant's legal name, as verified by the Internal Revenue Service or Social Security Administration.

(c) BACKGROUND CHECKS.

(A) When a homecare worker is approved without restrictions following a background check fitness determination, the approval must meet the homecare worker provider enrollment requirement statewide whether the qualified entity is a state-operated Department office or an AAA operated by a county, council of governments, or a non-profit organization.

(B) Background check approval is effective for two years unless:

(i) Based on possible criminal activity or other allegations against a homecare worker, a new fitness determination is conducted resulting in a change in approval status; or

(ii) Approval has ended because the Department has inactivated or terminated a homecare worker's provider enrollment for one or more reasons described in this rule or OAR 411-031-0050.

(C) Prior background check approval for another Department provider type is inadequate to meet background check requirements for homecare worker enrollment.

(D) Background rechecks are conducted at least every other year from the date a homecare worker is enrolled. The Department/AAA may conduct a recheck more frequently based on additional information discovered about a homecare worker, such as possible criminal activity or other allegations.

(d) RESTRICTED PROVIDER ENROLLMENT.

(A) The Department/AAA may enroll an applicant as a restricted homecare worker. A restricted homecare worker may only provide services to a specific consumer.

(i) Unless disqualified under OAR 407-007-0275, the Department/AAA may approve a homecare worker with a prior criminal record under a restricted enrollment to provide services to a specific consumer who is a family member, neighbor, or friend after conducting a weighing test as described in OAR 407-007-0200 to 407-007-0370.

(ii) Based on an applicant's lack of skills, knowledge, or abilities, the Department/AAA may approve the applicant as a restricted homecare worker to provide services to a specific consumer who is a family member, neighbor, or friend.

(iii) Based on an exception to the age requirements for provider enrollment approved by the Department as described in subsection (a)(E) of this section, a homecare worker who is at least 16 years of age may be approved as a restricted homecare worker.

(B) To remove restricted homecare worker status and be designated as a career homecare worker, the restricted homecare worker must complete a new application and background check and be approved by the Department/AAA.

(e) HOMECARE WORKER ORIENTATION. Homecare workers must participate in an orientation arranged through a Department/AAA office. The orientation must occur within the first 30 days after the homecare worker becomes enrolled in the Consumer-Employed Provider Program and prior to beginning work for any specific Department/AAA consumers. When completion of an orientation is not possible within those timelines, orientation must be completed within 90 days of being enrolled. If a homecare worker fails to complete an orientation within 90 days of provider enrollment, the homecare worker's provider number is inactivated and any authorization for payment of services is discontinued.

(f) INACTIVATED PROVIDER ENROLLMENT. A homecare worker's provider enrollment may be inactivated when:

(A) The homecare worker has not provided any paid services to any consumer in the last 12 months;

(B) The homecare worker's background check results in a closed case pursuant to OAR 407-007-0325;

(C) The homecare worker informs the Department/AAA the homecare worker is no longer providing services in Oregon;

(D) The homecare worker fails to participate in an orientation arranged through a Department/AAA office within 90 days of provider enrollment;

(E) The homecare worker, who at the time is not providing any paid services to consumers, is being investigated by Adult Protective Services for suspected abuse that poses imminent danger to current or future consumers; or

(F) The homecare worker's provider payments, all or in part, have been suspended based on a credible allegation of fraud pursuant to federal law under 42 CFR 455.23.

(9) PAID LEAVE.

(a) LIVE-IN HOMECARE WORKERS. Irrespective of the number of consumers served, the Department authorizes one twenty-four hour period of leave each month when a live-in homecare worker or spousal pay provider is the only live-in provider during the course of a month. For any part of a month worked, the live-in homecare worker receives a proportional share of the twenty-four hour period of leave authorization. A prorated share of the twenty-four hours is allocated proportionately to each live-in when there is more than one live-in provider per consumer.

(A) ACCUMULATION AND USAGE FOR LIVE-IN PROVIDERS. A live-in homecare worker may not accumulate more than 144 hours of accrued leave. A consumer-employer, homecare worker, and case manager must coordinate the timely use of accrued hours. Live-in homecare workers must take vacation leave in twenty-four hour increments or in hourly increments of at least one but not more than twelve hours. A live-in homecare worker must take accrued leave while employed as a live-in.

(B) THE RIGHT TO RETAIN LIVE-IN PAID LEAVE. A live-in homecare worker retains the right to access earned paid leave when terminating employment with one employer, so long as the homecare worker is employed with another employer as a live-in within one year of separation.

(C) TRANSFERABILITY OF LIVE-IN PAID LEAVE. A live-in homecare worker who converts to hourly or separates from live-in service and returns as an hourly homecare worker within one year from the last day of live-in services is credited with their unused hours of leave up to a maximum of 32 hours.

(D) CASH OUT OF PAID LEAVE.

(i) The Department pays live-in homecare workers 50 percent of all unused paid leave accrued as of January 31 of each year. The balance of paid leave is reduced 50 percent with the cash out.

(ii) Vouchers requesting payment of paid leave received after January 31 may only be paid up to the amount of remaining unused paid leave.

(iii) A live-in homecare worker providing live-in services seven days per week for one consumer-employer may submit a request for payment of 100 percent of unused paid leave if:

(I) The live-in homecare worker's consumer-employer is no longer eligible for in-home services described in OAR chapter 411, division 030; and

(II) The live-in homecare worker does not have alternative residential housing.

(iv) If a request for payment of 100 percent of unused paid leave based on subparagraph (D)(iii)(I) and (II) of this subsection is granted, the homecare's paid leave balance is reduced to zero.

(b) HOURLY HOMECARE WORKERS.

(A) On July 1st of each year, active homecare workers who worked 80 authorized and paid hours in any one of the three months that immediately precede July (April, May, June) are credited with one 16 hour block of paid leave to use during the current fiscal biennium (July 1 through June 30) in which the paid leave was accrued.

(B) On February 1st of each year, active homecare workers who worked 80 authorized and paid hours in any one of the three months that immediately precede February (November, December, January) are credited with one 16 hour block of paid leave.

(C) One 16 hour block of paid leave is credited to each eligible homecare worker, irrespective of the number of consumers the homecare worker serves. Such leave may not be cumulative from biennium to biennium.

(D) UTILIZATION OF HOURLY PAID LEAVE.

(i) Time off must be utilized in one eight hour block subject to authorization. If a homecare worker's normal workday is less than eight hours, the time off may be utilized in blocks equivalent to the homecare worker's normal workday. Any remaining hours that are less than a normally scheduled workday may be taken as a single block.

(ii) Hourly homecare workers may take unused paid leave when the homecare worker's employer is temporarily unavailable for the homecare worker to provide services. In all other situations, a homecare worker who is not working during a month is not eligible to use paid time off in that month.

(E) LIMITATIONS OF HOURLY PAID LEAVE. Homecare workers may not be compensated for paid leave unless the time off work is actually taken except as noted in subsection (b)(G) of this section.

(F) TRANSFERABILITY OF HOURLY PAID LEAVE. An hourly homecare worker who transfers to work as a live-in homecare worker (within the biennium that the hourly leave is earned) maintains the balance of hourly paid leave and begins accruing live-in paid leave.

(G) CASH OUT OF PAID LEAVE.

(i) The Department pays hourly providers for all unused paid leave accrued as of January 31 of each year. The balance of paid leave is reduced to zero with the cash out.

(ii) Vouchers requesting payment of paid leave received after January 31 may not be paid if paid leave has already been cashed out.

(10) DEPARTMENT FISCAL AND ACCOUNTABILITY RESPONSIBILITY.

(a) DIRECT SERVICE PAYMENTS. The Department makes payment to a homecare worker on behalf of a consumer for all in-home services. The payment is considered full payment for the services rendered. Under no circumstances is a homecare worker to demand or receive additional payment for services from a consumer or any other source. Additional payment to homecare workers for the same services covered by home and community-based waivered or state plan services is prohibited.

(b) TIMELY SUBMISSION OF CLAIMS. In accordance with OAR 410-120-1300, all claims for services must be submitted within 12 months of the date of service.

(c) ANCILLARY CONTRIBUTIONS.

(A) FEDERAL INSURANCE CONTRIBUTIONS ACT (FICA). Acting on behalf of a consumer-employer, the Department applies applicable FICA regulations and:

(i) Withholds a homecare worker-employee contribution from payments; and

(ii) Submits the consumer-employer contribution and the amounts withheld from the homecare worker-employee to the Social Security Administration.

(B) BENEFIT FUND ASSESSMENT. The Workers' Benefit Fund pays for programs that provide direct benefits to injured workers and the workers' beneficiaries and assist employers in helping injured workers return to work. The Department of Consumer and Business Services sets the Workers' Benefit Fund assessment rate for each calendar year. The Department calculates the hours rounded up to the nearest whole hour and deducts an amount rounded up to the nearest cent. Acting on behalf of the consumer-employer, the Department:

(i) Deducts a homecare worker-employees' share of the Benefit Fund assessment rate for each hour or partial hour worked by each paid homecare worker;

(ii) Collects the consumer-employer's share of the Benefit Fund assessment for each hour or partial hour of paid services received; and

(iii) Submits the consumer-employer's and homecare worker-employee's contributions to the Workers' Benefit Fund.

(C) The Department pays the consumer-employer's share of the unemployment tax.

(d) ANCILLARY WITHHOLDINGS. For the purposes of this subsection of the rule, "labor organization" means any organization that represents employees in employment relations.

(A) The Department deducts a specified amount from the homecare worker-employee's monthly salary or wages for payment to a labor organization.

(B) In order to receive payment, a labor organization must enter into a written agreement with the Department to pay the actual administrative costs of the deductions.

(C) The Department pays the deducted amount to the designated labor organization monthly.

(e) STATE AND FEDERAL INCOME TAX WITHHOLDING.

(A) The Department withholds state and federal income taxes on all payments to homecare workers, as indicated in the Collective Bargaining Agreement.

(B) A homecare worker must complete and return a current Internal Revenue Service W-4 form to the Department/AAA's local office. The Department applies standard income tax withholding practices in accordance with 26 CFR 31.

(11) REIMBURSEMENT FOR SERVICE PLAN RELATED TRANSPORTATION.

(a) A homecare worker may be reimbursed at $0.485 cents per mile when the homecare worker uses his or her own personal motor vehicle for service plan related transportation, if prior authorized by a consumer's case manager. If unscheduled transportation needs arise during non-office hours, the homecare worker must provide an explanation as to the need for the transportation and the transportation must be approved by the consumer's case manager prior to reimbursement.

(b) Medical transportation through the Division of Medical Assistance Programs (DMAP), volunteer transportation, and other transportation services included in the service plan is considered a prior resource.

(c) The Department is not responsible for vehicle damage or personal injury sustained when a homecare worker uses his or her own personal motor vehicle for DMAP or service plan related transportation, except as may be covered by workers' compensation.

(12) BENEFITS. Workers' compensation and health insurance are available to eligible homecare workers as described in the Collective Bargaining Agreement. In order to receive homecare worker services, a consumer-employer must consent and provide written authorization to the Department for the provision of workers' compensation insurance for the consumer-employer's employee.

(13) OVERPAYMENTS. An overpayment is any payment made to a homecare worker by the Department that is more than the homecare worker is authorized to receive.

(a) Overpayments are categorized as follows:

(A) ADMINISTRATIVE ERROR OVERPAYMENT. The Department failed to authorize, compute, or process the correct amount of in-home service hours or wage rate.

(B) PROVIDER ERROR OVERPAYMENT. The Department overpays the homecare worker due to a misunderstanding or unintentional error.

(C) FRAUD OVERPAYMENT. "Fraud" means taking actions that may result in receiving a benefit in excess of the correct amount, whether by intentional deception, misrepresentation, or failure to account for payments or money received. "Fraud" also means spending payments or money the homecare worker was not entitled to and any act that constitutes fraud under applicable federal or state law (including 42 CFR 455.2). The Department determines, based on a preponderance of the evidence, when fraud has resulted in an overpayment. The Department of Justice, Medicaid Fraud Unit determines when to pursue a Medicaid fraud allegation for prosecution.

(b) Overpayments are recovered as follows:

(A) Overpayments are collected prior to garnishments, such as child support, Internal Revenue Service back taxes, or educational loans.

(B) Administrative or provider error overpayments are collected at no more than 5 percent of the homecare worker's gross wages.

(C) The Department determines when a fraud overpayment has occurred and the manner and amount to be recovered.

(D) When an individual is no longer employed as a homecare worker, any remaining overpayment is deducted from the individual's final check. The individual is responsible for repaying an overpayment in full when the individual's final check is insufficient to cover the remaining overpayment.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020, 410.070, 410.612 & 410.614
Hist.: SPD 17-2004, f. 5-28-04, cert.ef. 6-1-04; SPD 40-2004(Temp), f. 12-30-04, cert. ef. 1-1-05 thru 6-30-05; SPD 10-2005, f. & cert. ef. 7-1-05; SPD 15-2006, f. 4-26-06, cert. ef. 5-1-06; SPD 28-2006(Temp), f. 10-18-06, cert. ef. 10-23-06 thru 4-20-07; SPD 4-2007, f. 4-12-07, cert. ef. 4-17-07; SPD 18-2007(Temp), f. 10-30-07, cert. ef. 11-1-07 thru 4-29-08; SPD 6-2008, f. 4-28-08, cert. ef. 4-29-08; SPD 16-2009(Temp), f. & cert. ef. 12-1-09 thru 5-30-10; SPD 3-2010, f. 5-26-10, cert. ef. 5-30-10; SPD 4-2010(Temp), f. 6-23-10, cert. ef. 7-1-10 thru 12-28-10; SPD 26-2010, f. 11-29-10, cert. ef. 12-1-10; SPD 13-2012(Temp), f. & cert. ef. 9-26-12 thru 3-25-13; SPD 4-2013, f. 3-25-13, cert. ef. 3-26-13; SDP 18-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

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Rule Caption: State Plan Personal Care Services
Adm. Order No.: SPD 19-2013(Temp)
Filed with Sec. of State: 7-1-2013
Certified to be Effective: 7-1-13 thru 12-28-13
Notice Publication Date:
Rules Amended: 411-034-0000, 411-034-0010, 411-034-0020, 411-034-0030, 411-034-0035, 411-034-0040, 411-034-0050, 411-034-0055, 411-034-0070, 411-034-0090
Subject: The Department of Human Services (Department) is immediately amending the State Plan personal care services rules in OAR chapter 411, division 034 to:

Modify the authorization of State Plan personal care service hours to allow individuals with needs that exceed the current 20 hour per month payment limitation to request an exception for additional hours;

Correctly reflect personal support workers as providers of State Plan personal care services;

Update the definitions to provide consistency with terms used for services for older adults, individuals with physical disabilities, and individuals with intellectual or developmental disabilities; and

Clarify provider qualifications, enrollment, employee-employer relationship, termination, and appeal rights.
Rules Coordinator: Christina Hartman—(503) 945-6398

411-034-0000
Purpose

The rules in OAR chapter 411, division 034 ensure State Plan personal care services support and augment independence, empowerment, dignity, and human potential through the provision of flexible, efficient, and

suitable services to individuals eligible for state plan services. State Plan personal care services are intended to supplement an individual's own personal abilities and resources.

Stat. Auth.: ORS 409.010, 410.020 & 410.070
Stats. Implemented: ORS 410.020, 410.070 & 410.710
Hist.: SSD 2-1996, f. 3-13-96, cert. ef. 3-15-96; SPD 35-2004, f. 11-30-04, cert. ef. 12-1-04; SPD 16-2007, f. 10-4-07, cert. ef. 10-5-07; SPD 15-2010(Temp), f. & cert. ef. 6-30-10 thru 12-27-10; SPD 18-2010(Temp), f. & cert. ef. 7-29-10 thru 12-27-10; Administrative correction 1-25-11; SDP 19-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-034-0010
Definitions

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 034:

(1) "Area Agency on Aging (AAA)" means the Department designated Area Agency on Aging (AAA) charged with the responsibility to provide a comprehensive and coordinated system of services to older adults or individuals with physical disabilities in a planning and service area. The terms AAA and Area Agency on Aging are inclusive of both Type A and Type B Area Agencies on Aging as defined in ORS 410.040 and described in ORS 410.210 to 410.300.

(2) "Assistance" means an individual requires help from another person with personal care or supportive services as described in OAR 411-034-0020. Assistance may include cueing, monitoring, reassurance, redirection, set-up, hands-on, or standby assistance as defined in OAR 411-015-0005. Assistance may also require verbal reminding to complete one of the tasks described in OAR 411-034-0020.

(3) "Assistive Devices" means any category of durable medical equipment, mechanical apparatus, electrical appliance, or instrument of technology used to assist and enhance an individual's independence in performing any task described in OAR 411-034-0020.

(4) "Assistive Supports" means the aid of service animals, general household items, or furniture used to assist and enhance an individual's independence in performing any task described in OAR 411-034-0020.

(5) "Background Check" means a criminal records check and abuse check as defined in OAR 407-007-0210 (Criminal Records and Abuse Check for Providers).

(6) "Case Management" means the functions performed by a case manager as described in OAR 411-028-0040, the functions performed by a services coordinator as described in OAR 411-320-0090, or the functions performed by a personal agent as described in OAR chapter 411, division 340. Case management includes determining service eligibility, developing a plan of authorized services, and monitoring the effectiveness of services and supports.

(7) "Case Manager" means a Department employee, services coordinator, or personal agent who assesses the service needs of an applicant, determines eligibility, and offers service choices to an eligible individual. A case manager authorizes and implements an individual's plan for services and monitors the services delivered.

(8) "Central Office" means the main office of the Department, Division, or Designee.

(9) "Community Developmental Disability Program (CDDP)" means the Department's designee that is responsible for the planning and delivery of services for individuals with intellectual or developmental disabilities according to OAR chapter 411, division 320. A CDDP operates in a specific geographic service area of the state under a contract with the Department, local mental health authority, or other entity as contracted by the Department.

(10) "Contracted In-Home Care Agency" means an entity (described in OAR chapter 333, division 536) that contracts with the Department to provide personal care to individuals served by the Department under Title XIX.

(11) "Cost Effective" means being responsible and accountable with Department resources by offering choices that may or may not be paid for by the Department. Cost effective choices may include other programs available from the Department, the utilization of assistive devices or assistive supports, natural supports, architectural modifications, or alternative service resources (defined in OAR 411-015-0005).

(12) "Delegated Nursing Task" means a registered nurse (RN) authorizes an unlicensed person (defined in OAR 851-047-0010) to provide a nursing task normally requiring the education and license of an RN. In accordance with 851-047-0000, 851-047-0010, and 851-047-0030, the RN's written authorization of a delegated nursing task includes assessing a specific eligible individual, evaluating an unlicensed person's ability to perform a specific nursing task, teaching the nursing task, and supervising and re-evaluating the individual and the unlicensed person at regular intervals.

(13) "Department" means the Department of Human Services.

(14) "Designee" means an organization with which the Department contracts or has an interagency agreement.

(15) "Developmental Disability" as defined in OAR 411-320-0080 and described in 411-320-0080.

(16) "Division" means the:

(a) Oregon Health Authority, Addictions and Mental Health Division (AMHD);

(b) Department of Human Services, Aging and People with Disabilities Division (APD);

(c) Area Agencies on Aging (AAA);

(d) Department of Human Services, Self-Sufficiency Programs (SSP);

(e) Department of Human Services, Office of Developmental Disability Services (ODDS);

(f) Community Developmental Disability Program (CDDP); and

(g) Support Services Brokerage.

(17) "Fiscal Improprieties" means a homecare or personal support worker committed financial misconduct involving an individual's money, property, or benefits.

(a) Improprieties include but are not limited to financial exploitation, borrowing money from the individual, taking the individual's property or money, having the individual purchase items for the homecare or personal support worker, forging the individual's signature, falsifying payment records, claiming payment for hours not worked, or similar acts intentionally committed for financial gain.

(b) Fiscal improprieties do not include the exchange of money, gifts, or property between a homecare or personal support worker whose employer is a relative unless an allegation of financial exploitation, as defined in OAR 411-020-0002 or 407-045-0260, has been substantiated based on an adult protective services investigation.

(18) "Guardian" means a parent for an individual less than 18 years of age or a person or agency appointed and authorized by the courts to make decisions about services for the individual.

(19) "Homecare Worker" means a provider, as described in OAR 411-031-0040, that is directly employed by an eligible individual to provide State Plan personal care services to older adults and individuals with physical disabilities. The term homecare worker does not include a personal support worker enrolled through the Office of Developmental Disability Services or the Addictions and Mental Health Division.

(20) "Individual" means the person applying for or determined eligible for State Plan personal care services.

(21) "Intellectual Disability" as defined in OAR 411-320-0020 and described in OAR 411-320-0080.

(22) "Lacks the Skills, Knowledge, and Ability to Adequately or Safely Perform the Required Work" means a homecare or personal support worker does not possess the skills to perform services needed by individuals receiving services from the Department. The homecare or personal support worker may not be physically, mentally, or emotionally capable of providing services to individuals. The homecare or personal support worker's lack of skills may put individuals at risk because the homecare or personal support worker fails to perform, or learn to perform, the duties needed to adequately meet the needs of the individuals.

(23) "Legal Representative" means:

(a) For a child, the parent or step-parent unless a court appoints another person or agency to act as the guardian; and

(b) For an adult, a spouse, a family member who has legal custody or legal guardianship according to ORS 125.005, 125.300, 125.315, and 125.310, an attorney at law who has been retained by or for an individual, or a person or agency authorized by the courts to make decisions about services for an individual.

(24) "Long Term Care Community Nursing" means the nursing services described in OAR chapter 411, division 048.

(25) "Natural Supports" or "Natural Support System" means the resources available to an individual from the individual's community and the individual's relatives, friends, significant others, neighbors, and roommates that possess the skills and abilities to provide services. Services provided by natural supports are voluntary and not paid for by the Department.

(26) "Ostomy" means assistance that an individual needs with a colostomy, urostomy, or ileostomy tube or opening used for elimination.

(27) "Personal Agent" means a person who works directly with an individual and the individual's family to provide or arrange for services and supports, is a case manager for the provision of case management services, meets the qualifications set forth in OAR 411-340-0150, and is a trained employee of a support services brokerage or a person who has been engaged under contract to the brokerage to allow the brokerage to meet

responsibilities in geographic areas where personal agent resources are severely limited.

(28) "Personal Care" means the functional activities described in OAR 411-034-0020 that an individual requires for continued well-being.

(29) "Personal Support Worker" means:

(a) A provider:

(A) Who is hired by an individual with an intellectual or developmental disability or the individual's representative;

(B) Who receives money from the Department for the purpose of providing services to an individual with an intellectual or developmental disability in the individual's home or community; and

(C) Whose compensation is provided in whole or in part through the Department or Community Developmental Disability Program.

(b) This definition of personal support worker is intended to reflect the term as defined in ORS 410.600.

(30) "Provider" or "Qualified Provider" means a homecare worker or personal support worker that meets the qualifications in OAR 411-034-0050 that performs State Plan personal care services.

(31) "Provider Enrollment" means the homecare worker's or personal support worker's authorization to work as a provider employed by an eligible individual, for the purpose of receiving payment for services authorized by the Department. Provider enrollment includes the issuance of a Medicaid provider number.

(32) "Provider Number" means an identifying number issued to each homecare worker or personal support worker who is enrolled as a provider through the Department.

(33) "Representative" means:

(a) A person appointed by an individual to participate in service planning on the individual's behalf that is either the individual's guardian or natural support with longstanding involvement in assuring the individual's health, safety and welfare; and

(b) For the purpose of obtaining State Plan personal care services through a homecare or personal support worker, the person selected by an individual or the individual's legal representative to act on the individual's behalf to provide the employer responsibilities described in OAR 411-034-0040.

(34) "Respite" means services for the relief of a person normally providing supports to an individual unable to care for him or herself.

(35) "Service Need" means the assistance with personal care and supportive services needed by an individual served by the Department under Title XIX.

(36) "Service Plan" or "Service Authorization" means an individual's written plan for services that identifies:

(a) The individual's qualified provider who shall deliver the authorized services;

(b) The date when the provision of services begins; and

(c) The maximum monthly hours of personal care and supportive services authorized by the Department or the Department's designee.

(37) "Services Coordinator" means an employee of a Community Developmental Disability Program or other agency that contracts with the county or Department, who is selected to plan, procure, coordinate, monitor an individual's plan for services, and to act as a proponent for individuals with intellectual or developmental disabilities.

(38) "State Plan Personal Care Services" means the assistance with personal care and supportive services described in OAR 411-034-0020 provided to an individual by a homecare worker or personal support worker. The assistance may include cueing, monitoring, reassurance, redirection, set-up, hands-on, or standby assistance as defined in OAR 411-015-0005. The assistance may also require verbal reminding to complete one of the personal care tasks described in OAR 411-034-0020.

(39) "Sub-Acute Care Facility" means a care center or facility that provides short-term rehabilitation and complex medical services to an individual with a condition that does not require acute hospital care but prevents the individual from being discharged to his or her home.

(40) "Support Services Brokerage (Brokerage)" means an entity, or distinct operating unit within an existing entity, that uses the principles of self-determination to perform the functions listed in OAR 411-340-0120 associated with planning and implementation of support services for individuals with intellectual or developmental disabilities.

(41) "These Rules" mean the rules in OAR chapter 411, division 034.

Stat. Auth.: ORS 410.020 & 410.070

Stats. Implemented: ORS 410.020, 410.070, 410.710 & 411.675

Hist.: SSD 2-1996, f. 3-13-96, cert. ef. 3-15-96; SPD 35-2004, f. 11-30-04, cert. ef. 12-1-04; SPD 16-2007, f. 10-4-07, cert. ef. 10-5-07; SPD 31-2010, f. 12-29-10, cert. ef. 1-1-11; SDP 19-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-034-0020

State Plan Personal Care Services

(1) State Plan personal care services are essential services that enable an individual to move into or remain in his or her own home. State Plan personal care services are provided in accordance with an individual's authorized plan for services by a homecare or personal support worker meeting the requirements in OAR 411-034-0050.

(a) To receive State Plan personal care services, an individual must demonstrate the need for assistance with personal care and supportive services and meet the eligibility criteria described in OAR 411-034-0030.

(b) State Plan personal care services are provided directly to an eligible individual and are not meant to provide respite or other services to an individual's natural support system. State Plan personal care services may not be implemented for the purpose of benefiting an individual's family members or the individual's household in general.

(c) State Plan personal care services are limited to 20 hours per month per eligible individual.

(d) To meet an extraordinary personal care or supportive services need, an individual may request an exception to the 20 hour per month limitation. An exception must be requested through the central office of the Division serving the individual. The Division has up to 45 days upon receipt of the exception request to determine whether an individual's assessed personal care and supportive services needs warrant exceeding the 20 hour per month limitation.

(2) Personal care services include:

(a) Basic personal hygiene — providing or assisting an individual with such needs as bathing (tub, bed bath, shower), washing hair, grooming, shaving, nail care, foot care, dressing, skin care, mouth care, and oral hygiene;

(b) Toileting, bowel, or bladder care — assisting to and from bathroom, on and off toilet, commode, bedpan, urinal, or other assistive device used for toileting, changing incontinence supplies, following a toileting schedule, cleansing an individual or adjusting clothing related to toileting, emptying a catheter drainage bag or assistive device, ostomy care, and bowel care;

(c) Mobility, transfers, or repositioning — assisting an individual with ambulation or transfers with or without assistive devices, turning an individual or adjusting padding for physical comfort or pressure relief, and encouraging or assisting with range-of-motion exercises;

(d) Nutrition — preparing meals and special diets, assisting with adequate fluid intake or adequate nutrition, assisting with food intake (feeding), monitoring to prevent choking or aspiration, assisting with special utensils, cutting food, and placing food, dishes, and utensils within reach for eating;

(e) Medication or oxygen management — assisting with ordering, organizing, and administering oxygen or prescribed medications (including pills, drops, ointments, creams, injections, inhalers, and suppositories), monitoring for choking while taking medications, assisting with the administration of oxygen, maintaining clean oxygen equipment, and monitoring for adequate oxygen supply;

(f) Delegated nursing tasks as defined in OAR 411-034-0010.

(3) When any of the services listed in section (2) of this rule are essential to the health, safety, and welfare of an individual and the individual is receiving a personal care paid by the Department, the following supportive services may also be provided:

(a) Housekeeping tasks necessary to maintain the eligible individual in a healthy and safe environment, including cleaning surfaces and floors, making the individual's bed, cleaning dishes, taking out the garbage, dusting, and gathering and washing soiled clothing and linens. Only the housekeeping activities related to the eligible individual's needs may be considered in housekeeping;

(b) Arranging for necessary medical appointments including help scheduling appointments and arranging medical transportation services (described in OAR chapter 410, division 136) and assistance with mobility and transfers or cognition in getting to and from appointments or to an office within a medical clinic or center;

(c) Observing the individual's health status and reporting any significant changes to physicians, health care professionals, or other appropriate persons;

(d) First aid and handling of emergencies, including responding to medical incidents related to conditions such as seizures, spasms, or uncontrollable movements where assistance is needed by another person and responding to an individual's call for help during an emergent situation or for unscheduled needs requiring immediate response; and

(e) Cognitive assistance or emotional support provided to an individual by another person due to confusion, dementia, behavioral symptoms, or mental or emotional disorders. Cognitive assistance or emotional support includes helping the individual cope with change and assisting the individual with decision-making, reassurance, orientation, memory, or other cognitive symptoms.

(4) Payment may not be made for any of the following excluded services:

(a) Shopping;

(b) Transportation;

(c) Money management;

(d) Mileage reimbursement;

(e) Social companionship;

(f) Day care, adult day services (described in OAR chapter 411, division 066), respite, or baby-sitting services;

(g) Home delivered meals (described in OAR chapter 411, division 040) funded by Medicaid;

(h) Caring, grooming, or feeding pets or other animals; or

(i) Yard work, gardening, or home repair.

Stat. Auth.: ORS 409.010, 410.020, 410.070 & 410.608

Stats. Implemented: ORS 409.010, 410.020, 410.070 & 410.608

Hist.: SSD 2-1996, f. 3-13-96, cert. ef. 3-15-96; SPD 35-2004, f. 11-30-04, cert. ef. 12-1-04; SPD 9-2005, f. & cert. ef. 7-1-05; SPD 16-2007, f. 10-4-07, cert. ef. 10-5-07; SPD 31-2010, f. 12-29-10, cert. ef. 1-1-11; SDP 19-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-034-0030

Eligibility for State Plan Personal Care Services

(1) To be eligible for State Plan personal care services, an individual must:

(a) Require assistance as defined in OAR 411-034-0010 with one or more of the personal care tasks described in OAR 411-034-0020(2); and

(b) Be a current service recipient of at least one of the following programs defined in OAR 461-101-0010:

(A) EXT — Extended Medical Assistance;

(B) MAA — Medical Assistance Assumed;

(C) MAF — Medical Assistance to Families;

(D) OHP — Oregon Health Plan;

(E) OSIP-M — Oregon Supplemental Income Program — Medical (OSIPM);

(F) TANF — Temporary Assistance to Needy Families; or

(G) REF — Refugee Assistance.

(2) An individual is not eligible to receive State Plan personal care services if:

(a) The individual is receiving assistance with activities of daily living (as described in OAR 411-015-0006) from a licensed 24-hour residential services program (such as an adult foster home, assisted living facility, group home, or residential care facility);

(b) The individual is in a prison, hospital, sub-acute care facility, nursing facility, or other medical institution;

(c) The individual's service needs are met through the individual's natural support system;

(d) The individual receives services under other Medicaid home and community-based waivered services options;

(3) Payment for State Plan personal care services is not intended to replace the resources available to an individual from the individual's natural support system as defined in OAR 411-034-0010.

(4) State Plan personal care services are not intended to replace routine care commonly needed by an infant or child typically provided by the infant's or child's parent.

(5) State Plan personal care services may not be used to replace other governmental services.

(6) The Department, Division or Designee has the authority to close the eligibility and authorization for State Plan personal care services if an individual fails to:

(a) Employ a provider that meets the requirements in OAR 411-034-0050; or

(b) Receive personal care from a qualified provider paid by the Department for 30 continuous calendar days or longer.

Stat. Auth.: ORS 409.050, 410.070

Stats. Implemented: ORS 409.010, 410.020, 410.070, 410.608 & 410.710

Hist.: SSD 2-1996, f. 3-13-96, cert. ef. 3-15-96; SPD 35-2004, f. 11-30-04, cert. ef. 12-1-04; SPD 9-2005, f. & cert. ef. 7-1-05; SPD 16-2007, f. 10-4-07, cert. ef. 10-5-07; SDP 19-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-034-0035

Applying for State Plan Personal Care Services

(1) An individual with an intellectual or developmental disability eligible for or receiving services through the Department's Office of Developmental Disabilities Services (ODDS) or a community developmental disability program (CDDP) must apply for State Plan personal care services through the local CDDP or the local support services brokerage.

(2) An older adult or an individual with a physical disability eligible for or receiving case management services from the Department's Aging and People With Disabilities (APD) or Area Agency on Aging (AAA) must apply for State Plan personal care services through the local APD or AAA office.

(3) If an individual is receiving benefits through the Department's Self-Sufficiency Programs (SSP) and the individual --

(a) Is eligible for or receiving services through ODDS or a CDDP, the individual must apply for State Plan personal care services through the local CDDP or support services brokerage. If the individual is determined eligible for State Plan personal care services, the CDDP or support services brokerage is responsible for a service assessment and any planning and payment authorization.

(b) Is eligible for or receiving case management services through the local APD or AAA office, the individual must apply for State Plan personal care services through the local APD or AAA office. If the individual is determined eligible for State Plan personal care services, the local APD or AAA office is responsible for a service assessment and any planning and payment authorization.

(c) Is eligible for State Plan personal care services as described in OAR 309-016-0690, the individual must apply through a local Community Mental Health Program or agency contracted with the Oregon Health Authority, Addictions and Mental Health Division (AMHD).

(4) Individuals applying for State Plan personal care services that are not eligible for or receiving services through ODDS or APD are referred to the appropriate AMHD office.

Stat. Auth.: ORS 409.050, 410.070

Stats. Implemented: ORS 410.020, 410.070, 410.608, 410.710 & 411.116

Hist.: SPD 35-2004, f. 11-30-04, cert. ef. 12-1-04; SPD 16-2007, f. 10-4-07, cert. ef. 10-5-07; SPD 31-2010, f. 12-29-10, cert. ef. 1-1-11; SDP 19-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-034-0040

Employer-Employee Relationship

(1) EMPLOYER - EMPLOYEE RELATIONSHIP. The relationship between a provider and an eligible individual or the individual's representative is that of employer and employee.

(2) JOB DESCRIPTION. As an employer, it is the responsibility of an individual or the individual's representative to create and maintain a job description for a potential provider that is in coordination with the individual's plan for services.

(3) PROVIDER BENEFITS. The only benefits available to homecare and personal support workers are those negotiated in a collective bargaining agreement and provided in statute. The collective bargaining agreement does not include participation in the Public Employees Retirement System or the Oregon Public Service Retirement Plan. Homecare and personal support workers are not state or Division employees.

(4) EMPLOYER RESPONSIBILITIES. For an individual to be eligible for State Plan personal care services provided by a homecare worker or personal support worker, the individual or the individual's representative must demonstrate the ability to:

(a) Locate, screen, and hire a provider meeting the requirements in OAR 411-034-0050;

(b) Supervise and train a provider;

(c) Schedule work, leave, and coverage;

(d) Track the hours worked and verify the authorized hours completed by a provider;

(e) Recognize, discuss, and attempt to correct any performance deficiencies with the provider and provide appropriate, progressive, disciplinary action as needed; and

(f) Discharge an unsatisfactory provider.

(5) An eligible individual exercises control as the employer and directs the provider in the provision of the services.

(6) The Department makes payment for State Plan personal care services to the provider on an individual's behalf. Payment for services is not guaranteed until the Department, Division, or Designee has verified that an individual's provider meets the qualifications in OAR 411-034-0050.

(7) In order to receive State Plan personal care services from a personal support worker or homecare worker, an individual must be able to:

(a) Meet all of the employer responsibilities described in section (4) of this rule; or

(b) Designate a representative to meet the employer responsibilities described in section (4) of this rule.

(8) TERMINATION OF PROVIDER EMPLOYMENT. Termination and the grounds for termination of employment are determined by an individual or the individual's representative. An individual has the right to terminate an employment relationship with a provider at any time and for any reason. An individual or the individual's representative must establish an employment agreement at the time of hire. The employment agreement may include grounds for dismissal, notice of resignation, work scheduling, and absence reporting.

(9) After appropriate intervention, an individual unable to meet the employer responsibilities in section (4) of this rule may be determined ineligible for State Plan personal care services provided by a homecare worker or personal support worker.

(a) Contracted in-home care agency services are offered when an individual is ineligible for State Plan personal care services provided by a homecare worker or personal support worker. Other community-based or nursing facility services are offered to an individual if the individual meets the eligibility criteria for community-based or nursing facility services.

(b) An individual determined ineligible for State Plan personal care services provided by a homecare worker or personal support worker may request State Plan personal care services provided by a homecare worker or personal support worker at the individual's next annual re-assessment. Improvements in health and cognitive functioning may be factors in demonstrating the individual's ability to meet the employer responsibilities described in section (4) of this rule. The waiting period may be shortened if an individual is able to demonstrate the ability to meet the employer responsibilities sooner than the individual's next annual re-assessment.

(10) REPRESENTATIVE

(a) An individual or an individual's legal representative may designate a representative to act on the individual's behalf to meet the employer responsibilities in section (4) of this rule. An individual's legal representative may be designated as the individual's representative.

(b) The Department, Division, or Designee may deny an individual's request for a representative if the representative has --

(A) A history of a substantiated abuse of an adult as described in OAR chapter 411, division 020, OAR chapter 407, division 045, or OAR chapter 943, division 045;

(B) A history of founded abuse of a child as described in ORS 419B.005;

(C) Participated in billing excessive or fraudulent charges; or

(D) Failed to meet the employer responsibilities in section (4) of this rule, including previous termination as a result of failing to meet the employer responsibilities in section (4) of this rule.

(c) An individual is given the option to select another representative if the Department, Division, or Designee suspends, terminates, or denies an individual's request for a representative for the reasons described in subsection (b) of this section.

(d) An individual with a guardian must have a representative for service planning purposes. A guardian may designate themselves the individual's representative.

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 410.020, 410.070, 410.608, 410.710 & 411.590
Hist.: SPD 35-2004, f. 11-30-04, cert. ef. 12-1-04; SPD 16-2007, f. 10-4-07, cert. ef. 10-5-07; SDP 19-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-034-0050
Provider Qualifications for Enrollment

(1) A qualified provider is a person who, in the judgment of the Department, Division, or Designee, may demonstrate by background, skills, and abilities the skills, knowledge, and ability to perform, or to learn to perform, the required work.

(a) A qualified provider must maintain a drug-free work place.

(b) A qualified provider must complete the background check process described in OAR 407-007-0200 to 407-007-0370 with an outcome of approved or approved with restrictions. The Department, Division, or the Designee may allow a homecare worker or personal support worker to work on a preliminary basis in accordance with OAR 407-007-0315 if the homecare worker or personal support worker meets the other qualifications described in this rule.

(c) A qualified provider paid by the Department may not be an individual's legal representative.

(d) A qualified provider must be authorized to work in the United States in accordance with U.S. Department of Homeland Security, Bureau of Citizenship and Immigration rules.

(e) A qualified provider must be 18 years of age or older. A homecare worker enrolled in the Consumer-Employed Provider Program who is at least 16 years of age may be approved for restricted enrollment as a qualified provider, as described in OAR 411-031-0040.

(f) A qualified provider may be employed through a contracted in-home care agency or enrolled as a homecare worker or personal support worker under a provider number. Rates for services are established by the Department.

(g) Providers that provide State Plan personal care services --

(A) Enrolled in the Consumer-Employed Provider Program must meet all of the standards in OAR chapter 411, division 031.

(B) As personal support workers must meet the provider enrollment and termination criteria described in OAR 411-031-0040.

(2) BACKGROUND RECHECKS:

(a) Background rechecks are conducted at least every other year from the date a provider is enrolled. The Department, Division, or Designee may conduct a recheck more frequently based on additional information discovered about a provider, such as possible criminal activity or other allegations.

(b) Prior background check approval for another Department provider type is inadequate to meet background check requirements for homecare or personal support workers.

(c) A homecare or personal support worker's provider enrollment may be inactivated when the homecare or personal support worker fails to comply with the background recheck process. Once a provider's enrollment is inactivated, the provider must reapply and meet the standards described in this rule to reactivate his or her provider enrollment.

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 409.010, 410.020, 410.070 & 410.608
Hist.: SSD 2-1996, f. 3-13-96, cert. ef. 3-15-96; SPD 35-2004, f. 11-30-04, cert. ef. 12-1-04; SPD 16-2007, f. 10-4-07, cert. ef. 10-5-07; SDP 19-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-034-0055
Provider Termination

(1) The Department, Division, or Designee may deny or terminate a homecare worker's provider enrollment and provider number as described in OAR 411-031-0040.

(2) The Department, Division, or Designee may deny or terminate a personal support worker's provider enrollment and provider number when:

(a) The personal support worker has been appointed the legal guardian of an individual;

(b)The personal support worker's background check results in a closed case pursuant to OAR 407-007-0325;

(c) The personal support worker lacks the skills, knowledge, or ability to perform, or learn to perform, the required work;

(d) Violates the protective service and abuse rules in OAR chapter 411, division 020, OAR chapter 407, division 045, and OAR chapter 943, division 045;

(e) Commits fiscal improprieties;

(f) Fails to provide the authorized services required by an eligible individual;

(g) Has been repeatedly late in arriving to work or has absences from work not authorized in advance by an individual;

(h) Has been intoxicated by alcohol or drugs while providing authorized services to an individual or while in the individual's home;

(i) Has manufactured or distributed drugs while providing authorized services to an individual or while in the individual's home; or

(j) Has been excluded as a provider by the U.S. Department of Health and Human Services, Office of Inspector General, from participation in Medicaid, Medicare, or any other federal health care programs.

(3) A provider may contest the Department's, Division's, or Designee's decision to terminate the provider's enrollment and provider number.

(a) A designated Department, Division, or Designee employee reviews a termination and notifies the provider of his or her decision.

(b) A provider may file a request for a hearing with the Department's, Division's, or Designee's local office if all levels of administrative review have been exhausted and the provider continues to dispute the Department's, Division's, or Designee's decision. The local office files the request for a hearing with the Office of Administrative Hearings as described in OAR chapter 137, division 003. The request for a hearing must be filed within 30 calendar days of the date of the written notice from the Department, Division, or Designee.

(c) An Administrative Law Judge (ALJ) with the Office of Administrative Hearings determines whether the Department's, Division's, or the Designee's decision to terminate the provider enrollment number is affirmed or reversed. The ALJ issues a Final Order with the decision to all appropriate parties.

(d) No additional hearing rights have been granted to a provider by this rule other than the right to a hearing on the Department's, Division's, or Designee's decision to terminate provider enrollment.

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 409.010, 410.020, 410.070, & 411.675
Hist.: SPD 35-2004, f. 11-30-04, cert. ef. 12-1-04; SPD 9-2005, f. & cert. ef. 7-1-05; SPD 16-2007, f. 10-4-07, cert. ef. 10-5-07; SDP 19-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-034-0070
State Plan Personal Care Service Assessment, Authorization, and Monitoring

(1) Case Manager Responsibilities:

(a) Assessment and Re-Assessment:

(A) The Case Manager or designated person will meet in person with the individual to assess the individual's ability to perform the tasks listed in OAR 411-034-0020.

(B) The individual's natural supports may participate in the assessment if requested by the individual.

(C) The Case Manager will assess the individual's service needs, identify the resources meeting any, some or all of the person's needs, and determine if the individual is currently eligible for State Plan Personal Care or other services.

(D) The Case Manager will meet with the individual in person at least once every 365 days to review the individual's service needs.

(b) Service Planning:

(A) The Case Manager will prepare a service plan identifying those tasks for which the individual requires assistance and the monthly number of authorized hours of service. The Case Manager will document the natural supports that currently meet some or all of those assistance needs.

(B) The service plan will describe the tasks to be performed by the qualified provider and will authorize the maximum monthly hours that can be reimbursed for those services.

(C) When developing service plans, Case Managers will consider the cost effectiveness of services that adequately meet the individual's service needs.

(D) Payment for State Plan Personal Care services must be prior authorized by the Case Manager based on the service needs of the individual as documented in the written service plan.

(c) Ongoing Monitoring and Authorization:

(A) When there is an indication that the individual's Personal Assistance Service needs have changed, the Case Manager will conduct a re-assessment in person with the individual (and any natural supports if requested by the individual).

(B) Following annual re-assessments and those conducted after a change in Personal Assistance Service needs, the Case Manager will review service eligibility, the cost effectiveness of the service plan and whether the services provided are meeting the identified service needs of the individual. The Case Manager may adjust the hours or services in the plan and will authorize a new service plan, if appropriate, based on the individual's current service needs.

(d) Ongoing Case Management: The Case Manager will provide ongoing coordination of State Plan Personal Care services, including authorizing changes in service providers and service hours, addressing risks, and providing information and referral to the individual when indicated.

(e) Contract Registered Nurse Referral: A Contract Registered Nurse (RN) is a licensed, registered nurse who has been approved under a contract or provider agreement with Seniors and People with Disabilities Division to provide nursing assessment for indicators identified in section (1)(f)(A) of this rule and may provide on-going nursing services as identified in section (1)(f)(B) of this rule to certain individuals served by the Division. Individuals served by the Contract RN Program are primarily seniors and people with physical disabilities.

(f) The Case Manager may refer a Contract RN where available, for nursing assessment and monitoring when it appears the individual needs assistance to manage health care needs and may need delegated nursing tasks, nurse assessment and consultation, teaching, or services requiring RN monitoring.

(A) Indicators of the need for Contract RN assessment and monitoring include:

(i) Complex health problem or multiple diagnoses resulting in the need for assistance with health care coordination;

(ii) Medical instability, as demonstrated by frequent emergency care, physician visits or hospitalizations;

(iii) Behavioral symptoms or changes in behavior or cognition;

(iv) Nutrition, weight, or dehydration issues;

(v) Skin breakdown or risk for skin breakdown;

(vi) Pain issues;

(vii) Medication safety issues or concerns;

(viii) A history of recent, frequent falls; or

(ix) The service provider would benefit from teaching or training about the health support needs of the eligible individual.

(B) Following the completion of an initial nursing assessment in the individual's home by the Contract RN, the provision of ongoing Contract RN services may be prior-authorized by the Case Manager and may include:

(i) Ongoing health monitoring and teaching for an eligible individual specific to the identified needs;

(ii) Medication education for an eligible individual and provider;

(iii) Instructing or training a provider or natural support to address an eligible individual's health needs;

(iv) Consultation with other health care professionals serving the eligible individual and advocating for the individual's medical and restorative needs in a non-facility setting; or

(v) Delegation of nursing tasks defined in OAR 411-034-0010 to a non-family provider.

(2) Contract RN Services:

(a) Assessment: A Contract Registered Nurse that accepts a referral from a Case Manager will assess the individual for health care needs, including the indicators identified in section (1)(d)(A) of this rule, in the individual's home.

(b) Nursing Plan of Care:

(A) The nursing plan of care developed by the Contract RN must comply with the Oregon State Board of Nursing Oregon Administrative Rules in chapter 851, divisions 045 and 047.

(B) The nursing plan of care developed by the Contract RN must be a written plan and must indicate the interventions needed, the expected outcomes of care and the plan for any follow-up nursing visits based on the individual's identified needs.

(C) The frequency of review will be based on the individual's needs, but the plan will be reviewed and approved by the Case Manager at least every 180 days. Any additional Contract RN services suggested by the review must be prior authorized by the Case Manager.

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 409.010, 410.020, 410.070, 410.608 & 410.710
Hist.: SSD 2-1996, f. 3-13-96, cert. ef. 3-15-96; SPD 35-2004, f. 11-30-04, cert. ef. 12-1-04; SPD 9-2005, f. & cert. ef. 7-1-05; SPD 16-2007, f. 10-4-07, cert. ef. 10-5-07; SDP 19-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-034-0090
Payment Limitations for State Plan Personal Care Services

(1) The number of State Plan personal care service hours authorized for an individual per calendar month is based on projected amounts of time to perform specific personal care and supportive services to the eligible individual. The total of these hours are limited to 20 hours per individual per month. Individuals whose assessed service needs exceed the 20 hour limit may receive approval for additional hours through the exception process described in OAR 411-034-0020. State Plan personal care service hours are authorized in accordance with an individual's service plan and may be scheduled throughout the month to meet the service needs of the individual.

(2) The monthly maximum hours for State Plan personal care services described in section (1) of this rule do not include authorized LTC Community Nurse assessment and monitoring services.

(3) The Department does not guarantee payment for State Plan personal care services until all acceptable provider enrollment standards have been verified and both the employer and provider have been formally notified in writing that payment by the Department is authorized.

(4) In accordance with OAR 410-120-1300, all provider claims for payment must be submitted within 12 months of the date of service.

(5) Payment may not be claimed by a provider until the hours authorized for the payment period have been completed, as directed by an eligible individual or the individual's representative.

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 410.020, 410.070, 410.710, 411.590 & 411.675
Hist.: SSD 2-1996, f. 3-13-96, cert. ef. 3-15-96; SPD 35-2004, f. 11-30-04, cert. ef. 12-1-04; SPD 16-2007, f. 10-4-07, cert. ef. 10-5-07

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Rule Caption: Children's Intensive In-Home Services for Children with Intellectual or Developmental Disabilities
Adm. Order No.: SPD 20-2013(Temp)
Filed with Sec. of State: 7-1-2013
Certified to be Effective: 7-1-13 thru 12-28-13

Notice Publication Date:
Rules Amended: 411-300-0110, 411-300-0120, 411-300-0130, 411-300-0140, 411-300-0150
Subject: The Department of Human Services (Department) is immediately amending the children's intensive in-home services rules for children with intellectual or developmental disabilities in OAR chapter 411, division 300 to:

Reflect new definitions applicable to Community First Choice State Plan services;

Specify the eligibility requirements to reflect changes made as a result of the Community First Choice State Plan;

Describe and coincide with the services available in the Community First Choice State Plan and Home and Community-Based Waiver amendments;

Require a functional needs assessment as part of a child's service planning process; and

Clarify the responsibilities of a services coordinator when developing a child's Plan of Care.
Rules Coordinator: Christina Hartman—(503) 945-6398

411-300-0110
Definitions

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 300:

(1) "Abuse" means abuse of a child as defined in ORS 419B.005.

(2) "Activities of Daily Living (ADL)" mean those personal, functional activities required by a child for continued well-being that are essential for health and safety.

(3) "Background Check" means a criminal records check and abuse check as defined in OAR 407-007-0210 (Criminal Records and Abuse Check for Providers).

(4) "Behavior Consultant" means a contractor with specialized skills who develops a Behavior Support Plan.

(5) "Behavior Support Plan (BSP)" means a written strategy based on person-centered planning and a functional assessment that outlines specific instructions for a provider to follow, to cause a child's challenging behaviors to become unnecessary, and to change the provider's own behavior, adjust environment, and teach new skills.

(6) "Behavior Criteria (Form DHS-0521)" means the assessment tool used by the Department to evaluate the intensity of a child's challenges and service needs and determine the service budget for the child.

(7) "Billing Provider" means an organization that enrolls and contracts with the Department to provide services through an employee and bills the Department for the provider's services.

(8) "Case Management" means an organized service to assist individuals to select, obtain, and utilize resources and services.

(9) "CDDP" means "Community Developmental Disability Program" as defined in this rule.

(10) "Child" means an individual under the age of 18, eligible for developmental disability services, and applying for or accepted for children's intensive in-home services under the ICF/IDD Behavioral Waiver.

(11) "Chore Services" mean the services described in OAR 411-300-0150 needed to maintain a clean, sanitary, and safe environment in a child's home. Chore services include heavy household chores such as washing floors, windows, and walls, tacking down loose rugs and tiles, and moving heavy items of furniture for safe access and egress. Chore services may include yard hazard abatement to ensure the outside of the home is safe for the child to traverse and enter and exit the home.

(12) "CIIS" means children's intensive in-home services.

(13) "Community Developmental Disability Program (CDDP)" means the entity that is responsible for the planning and delivery of services for children with intellectual or developmental disabilities according to OAR chapter 411, division 320. A CDDP operates in a specific geographic service area of the state under a contract with the Department, local mental health authority, or other entity as contracted by the Department.

(14) "Community First Choice State Plan" means Oregon's state plan amendment authorized under section 1915(k) of the Social Security Act.

(15) "Community Nursing Services" mean the services described in OAR 411-300-0150 that include nurse delegation and care coordination for a child living in his or her own home. Community nursing services do not include direct nursing care and are not covered by other Medicaid spending authorities

(16) "Cost Effective" means that in the opinion of a services coordinator, a specific service or item of equipment meets a child's needs and costs less than, or is comparable to, other service or equipment options considered.

(17) "Daily Activity Log" means the record of services provided to a child. The content and form of a daily activity log is agreed upon by both the child's parent and the child's services coordinator and documented in the child's Plan of Care.

(18) "Department" means the Department of Human Services (DHS). The term "Department" is synonymous with "Seniors and People with Disabilities Division (Division)".

(19) "Developmental Disability (DD)" means a neurological condition that originates in the developmental years, that is likely to continue, and significantly impacts adaptive behavior as diagnosed and measured by a qualified professional as described in OAR 411-320-0080.

(20) "Director" means the Director of the Department's Office of Developmental Disability Services or the Director's designee.

(21) "Environmental Accessibility Adaptations" mean the physical adaptations as described in OAR 411-300-0150 that are necessary to ensure the health, welfare, and safety of a child in the home, or that enable the child to function with greater independence in the home.

(22) "Exit" means termination or discontinuance of children's intensive in-home services.

(23) "Family Home" means a child's primary residence that is not under contract with the Department to provide services as a licensed, endorsed, or certified foster home, residential care facility, assisted living facility, nursing facility, or other residential support program site.

(24) "Family Training" means training and counseling services for the family of a child that increase the family's capacity to care for, support, and maintain the child in the home as described in OAR 411-300-0150.

(a) Family training includes:

(A) Instruction about treatment regimens and use of equipment specified in the child's Plan of Care;

(B) Information, education, and training about the child's intellectual or developmental disability, medical, or behavioral conditions; and

(C) Counseling for the family to relieve the stress associated with caring for a child with an intellectual or developmental disability.

(b) To determine who may receive family training, family means a unit of two or more persons that include at least one child with an intellectual or developmental disability where the primary caregiver is:

(A) Related to the child by blood, marriage, or legal adoption; or

(B) In a domestic relationship where partners share:

(i) A permanent residence;

(ii) Joint responsibility for the household in general (e.g. child-rearing, maintenance of the residence, basic living expenses); and

(iii) Joint responsibility for supporting the child and the child is related to one of the partners by blood, marriage, or legal adoption.

(25) "Founded Reports" means the Department's Children, Adults, and Families Division or Law Enforcement Authority (LEA) determination, based on the evidence, that there is reasonable cause to believe that conduct in violation of the child abuse statutes or rules has occurred and such conduct is attributable to the person alleged to have engaged in the conduct.

(26) "Functional Needs Assessment (FNAT)" means an assessment that documents the level of need, accommodates a child's participation in service planning, and includes:

(a) Completing a comprehensive and holistic assessment;

(b) Surveying physical, mental, and social functioning; and

(c) Identifying risk factors, choices and preferences, and service needs.

(27) "Home and Community-Based Waivered Services" mean the services approved by the Centers for Medicare and Medicaid Services in accordance with Section 1915(c) and 1115 of the Social Security Act.

(28) "ICF/IDD Behavioral Waiver" means the waiver program granted by the federal Centers for Medicare and Medicaid Services that allows Medicaid funds to be spent on children living in the family home who otherwise would have to be served in an intermediate care facility if the waiver program was not available.

(29) "In-Home Daily Care (IHDC)" means Medicaid state plan funded essential supportive daily care as described in OAR 411-300-0150 delivered by a qualified provider that enables a child to remain in, or return to, the family home.

(30) "Instrumental Activities of Daily Living (IADL)" mean those activities, other than activities of daily living, required to continue independent living.

(31) "Intellectual Disability" has the meaning set forth in OAR 411-320-0020 and described in OAR 411-320-0080.

(32) "Level of Care" means an assessment completed by a services coordinator has determined a child meets institutional level of care. A child meets institutional level of care for an intermediate care facility for individuals with intellectual or developmental disabilities if:

(a) The child has a condition of an intellectual disability or a developmental disability as defined in OAR 411-320-0020 and meets the eligibility criteria for developmental disability services as described in OAR 411-320-0080; and

(b) The child has a significant impairment in one or more areas of adaptive functioning. Areas of adaptive functioning include self direction, self care, home living, community use, social, communication, mobility, or health and safety.

(33) "Mandatory Reporter" means any public or private official as defined in OAR 407-045-0260 who comes in contact with and has reasonable cause to believe a child with or without an intellectual or developmental disability has suffered abuse, or comes in contact with any person whom the official has reasonable cause to believe abused a child, regardless of whether or not the knowledge of the abuse was gained in the reporter's official capacity. Nothing contained in ORS 40.225 to 40.295 affects the duty to report imposed by this section, except that a psychiatrist, psychologist, clergy, attorney, or guardian ad litem appointed under ORS 419B.231 is not required to report such information communicated by a person if the communication is privileged under ORS 40.225 to 40.295.

(34) "Natural Supports" or "Natural Support System" means the resources available from relatives, friends, significant others, neighbors, roommates, and the community. Services provided by natural supports are resources that are not paid for by the Department.

(35) "Nurse" means a person who holds a current license from the Oregon Board of Nursing as a registered nurse or licensed practical nurse pursuant to ORS chapter 678.

(36) "Nursing Care Plan" means the plan of care developed by a nurse that describes the medical, nursing, psychosocial, and other needs of a child and how those needs are met. The Nursing Care Plan includes the tasks that are taught or delegated to a parent or service provider.

(37) "OSIP-M" means Oregon Supplemental Income Program-Medical as defined in OAR 461-101-0010. OSIP-M is Oregon Medicaid insurance coverage for those who meet the eligibility criteria as described in OAR chapter 461.

(38) "Parent" means biological parent, adoptive parent, stepparent, or legal guardian.

(39) "Person-Centered Planning" means:

(a) A process, either formal or informal, for gathering and organizing information that helps:

(A) Determine and describe choices about personal goals, activities, and lifestyle preferences;

(B) Design strategies and networks of support to achieve goals and a preferred lifestyle using strengths, relationships, and resources; and

(C) Identify, use, and strengthen naturally occurring opportunities for support at home and in the community.

(b) The methods for gathering information vary, but all are consistent with a child's needs and preferences.

(40) "Personal Care Services" means assistance with activities of daily living, instrumental activities of daily living, and health-related tasks through cueing, monitoring, reassurance, redirection, set-up, hands-on, standby assistance, and reminding.

(41) "Plan of Care" means the written details of the supports, activities, and resources required for a child to achieve personal outcomes. Individual support needs are identified through a functional needs assessment. The manner in which services are delivered, service providers, and the frequency of services are reflected in a Plan of Care. The Plan of Care is developed at minimum annually to reflect decisions and agreements made during a person-centered process of planning and information gathering. The Plan of Care includes a Nursing Care Plan when one exists. The Plan of Care reflects whether services are provided through a waiver, state plan, or through a child's natural supports.

(42) "Positive Behavioral Theory and Practice" means a proactive approach to behavior and behavior interventions that:

(a) Emphasizes the development of functional alternative behavior and positive behavior intervention;

(b) Uses the least intervention possible;

(c) Ensures that abuse or demeaning interventions are never used; and

(d) Evaluates the effectiveness of behavior interventions based on objective data.

(43) "Primary Caregiver" means a child's parent, guardian, relative, or other non-paid parental figure that provides direct care at the times that a paid provider is not available.

(44) "Protective Physical Intervention (PPI)" means any manual physical holding of, or contact with, a child that restricts the child's freedom of movement. The term "protective physical intervention" is synonymous with "physical restraint".

(45) "Provider or Performing Provider" means a person who is qualified as described in OAR 411-300-0170 to receive payment from the Department for in-home daily care. Providers work directly with children. Providers may be employees of billing providers, employees of a child's parent, or independent contractors.

(46) "Respite" means intermittent services as described in OAR 411-300-0150 provided on a periodic basis, but not more than 14 consecutive days, for the relief of, or due to the temporary absence of a child's primary caregiver.

(47) "Service Budget" means the annual dollar amount allotted for the care of a child based on the behavior criteria. The service budget consists of in-home daily care and waivered services. The monthly service budget is 1/12th of the annual amount if the Plan of Care is developed for less than a full year. The service budget is flexible and may be distributed as necessary to meet the needs of a child as outlined in the child's Plan of Care.

(48) "Services Coordinator" means an employee of the Department, who ensures a child's eligibility for children's intensive in-home services and provides assessment, case management, service implementation, and evaluation of the effectiveness of the services.

(49) "Social Benefit" means a service or financial assistance provided to a family solely intended to assist a child to function in society on a level comparable to that of a person who does not have an intellectual or developmental disability. Social benefits are pre-authorized by a child's services coordinator and provided according to the description and financial limits written in a child's Plan of Care.

(a) Social benefits may not:

(A) Duplicate benefits and services otherwise available to persons regardless of intellectual or developmental disability;

(B) Replace normal parental responsibilities for the child's services, education, recreation, and general supervision;

(C) Provide financial assistance with food, clothing, shelter, and laundry needs common to people with or without disabilities; or

(D) Replace other governmental or community services available to the child or the child's family.

(b) Financial assistance provided as a social benefit may not exceed the actual cost of the support provided for the child to be supported in the family home.

(50) "Specialized Diet" means specially prepared food or particular types of food as described in OAR 411-300-0150, ordered by a physician and periodically monitored by a dietician, specific to a child's medical condition or diagnosis that are needed to sustain a child in the family home. Specialized diets are supplements and are not intended to meet a child's complete daily nutritional requirements.

(51) "Specialized Equipment and Supplies" mean devices, aids, controls, supplies, or appliances as described in OAR 411-300-0150 that meet applicable standards of manufacture, design, and installation that enable children to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. Specialized equipment and supplies do not include items not of direct benefit to a child.

(52) "Substantiated" means an abuse investigation has been completed by the Department or the Department's designee and the preponderance of the evidence establishes the abuse occurred.

(53) "Supplant" means take the place of.

(54) "Support" means the assistance that a child and the child's parent require, solely because of the effects of an intellectual or developmental disability, to maintain or increase the child's age-appropriate independence, achieve a child's age-appropriate community presence and participation, and to maintain the child in the family home. Support is subject to change with time and circumstances.

(55) "These Rules" mean the rules in OAR chapter 411, division 300.

(56) "Transportation" means services as described in OAR 411-300-0150 that allow a child to gain access to community services, activities, and resources that are not medical in nature.

(57) "Waivered Services" mean a menu of disability related services and supplies, exclusive of in-home daily care and the Oregon Health Plan, that are specifically identified by the ICF/IDD Behavioral Waiver.

(58) "Volunteer" means any person providing services without pay to support the services provided to a child.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 427.005, 427.007, 430.215
Hist.: SDSD 12-2002, f. 12-26-02, cert. ef. 12-28-02; SPD 19-2003(Temp), f. & cert. ef. 12-11-03 thru 6-7-04; SPD 13-2004, f. & cert. ef. 6-1-04; SPD 11-2009, f. 7-31-09, cert. ef. 8-1-09; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 5-2010, f. 6-29-10, cert. ef. 7-1-10; SPD 20-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-300-0120
Eligibility

(1) ELIGIBILITY. In order to be eligible for CIIS, a child must:

(a) Be under the age of 18;

(b) Be an Oregon resident who meets the citizenship and alien status requirements of OAR 461-120-0110;

(c) Be eligible for OSIP-M;

(d) Be determined eligible for developmental disability services by the CDDP of the child's county of residence as described in OAR 411-320-0080;

(e) After completion of an assessment, meet the level of care defined in OAR 411-300-0110;

(f) Be accepted by the Department by scoring greater than 200 on the behavior criteria within two months of starting services. To remain eligible, a child must maintain a score above 150 as determined during an annual re-eligibility assessment;

(g) Be financially and otherwise eligible to receive Medicaid services;

(h) Reside in the family home; and

(i) Be capable of being safely served in the family home. This includes but is not limited to the parent demonstrating the willingness, skills, and ability to provide the direct care as outlined in the Plan of Care in a cost effective manner as determined by the services coordinator within the limitations of OAR 411-300-0150 and participate in planning, monitoring, and evaluation of the CIIS provided.

(2) INELIGIBILITY. A child is not eligible for CIIS if the child:

(a) Resides in a hospital, school, sub-acute facility, nursing facility, intermediate care facility, residential facility, foster home, or other institution;

(b) Does not require waivered services, Community First Choice State Plan services, or has sufficient family, government, or community resources available to provide for his or her care; or

(c) Is not safely served in the family home as described in section (1)(i) of this rule.

(3) TRANSITION. A child whose score on the behavior criteria remains at 150 or less is transitioned out of CIIS within 90 days and at the end of the 90 day transition period must exit.

(a) When possible and agreed upon by the child's parent and services coordinator, CIIS are incrementally reduced during the 90 day transition period.

(b) A minimum of 30 days prior to exit, the services coordinator must coordinate and attend a transition planning meeting that includes a representative of the community developmental disability program, the parent, and any other person at the parent's request.

(4) EXIT. A child must exit from CIIS if the child no longer meets the eligibility criteria in section (1) of this rule or if the child has been transitioned out as described in section (3) of this rule, except when the child's parent appeals notice of intent to terminate services and requests continuing services as described in OAR 411-300-0210.

(5) WAIT LIST. A child eligible for CIIS may be placed on a wait list if the maximum numbers of children on the ICF/IDD Behavioral Waiver are already being served.

(a) The date the initial application for service is completed determines the order on the wait list. A child who was once served by CIIS, exited CIIS, reapplies, and currently meets all other criteria for eligibility, is put on the wait list as of the date the child's original application for services was complete.

(b) The date the application is complete is the date that the Department has the required demographic data on the child and a statement of developmental disability eligibility.

(c) Children on the wait list are served on a first come, first served basis as space on the ICF/IDD Behavioral Waiver allows.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 427.005, 427.007 & 430.215
Hist.: SDSD 12-2002, f. 12-26-02, cert. ef. 12-28-02; SPD 11-2009, f. 7-31-09, cert. ef. 8-1-09; SPD 20-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-300-0130
Plan of Care

(1) To develop the Plan of Care, the services coordinator must complete an FNAT using a person-centered planning approach and assess the service needs of the child. The assessment must take place in person and the services coordinator must interview the child's parent, other caregivers, or others requested by the child's parent when appropriate. The assessment must:

(a) Take place in the child's family home with both the child and the child's primary caregiver present;

(b) Identify the services for which the child is currently eligible;

(c) Identify the services currently being provided; and

(d) Identify all available family, private health insurance, and government or community resources that meet any, some, or all of the child's needs.

(2) The services coordinator must prepare, with the input of the parent and any other person at the parent's request, a written Plan of Care that identifies:

(a) The service needs of the child and the child's family;

(b) The most cost effective services for safely and appropriately meeting the child's service needs; and

(c) The methods, resources, and strategies that address some or all of the child's service needs;

(3) The Plan of Care must include:

(a) A description of the supports required, including the reason the support is necessary. For an initial or annual Plan of Care that is authorized after July 1, 2013, the description must be consistent with the FNAT;

(b) A list of personal, community, and public resources that are available to the child and how the resources may be applied to provide the required supports. Sources of support may include waivered or state plan services, state general funds, or natural supports;

(c) The maximum hours of authorized provider services;

(d) The annual and monthly service level;

(e) The number of hours of in-home daily care or behavior consultation authorized for the child;

(f) Additional services authorized by the Department for the child:

(g) The date of the next Plan of Care review that, at a minimum, must be completed within 12 months of the last Plan of Care; and

(h) The child's Nursing Care Plan, when one exists.

(4) The Plan of Care must be reviewed with the parent prior to implementation, signed by both the parent and the services coordinator, and a copy must be provided to the parent.

(5) The Plan of Care is translated, as necessary, upon request.

(6) Significant changes in the needs of the child must be reflected in the Plan of Care, as they occur, and a copy must be provided to the parent. Changes in service needs funded by the Department must be documented in a Plan of Care amendment signed by the parent and the services coordinator.

(7) The Plan of Care must be renewed at least every 12 months. Each new plan year begins on the anniversary date of the initial or previous plan date.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 427.005, 427.007 & 430.215
Hist.: SDSD 12-2002, f. 12-26-02, cert. ef. 12-28-02; SPD 11-2009, f. 7-31-09, cert. ef. 8-1-09; SPD 20-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-300-0140
Rights of the Child

(1) When interventions in the behavior of a child are necessary, the interventions must be done in accordance with positive behavioral theory and practice as defined in OAR 411-300-0110.

(2) The least intrusive intervention to keep the child and others safe must be used.

(3) Abusive or demeaning interventions must never be used.

(4) When protective physical interventions are required, the protective physical intervention must only be used as a last resort and providers must be appropriately trained as per the child's Behavior Support Plan.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 427.005, 427.007 & 430.215
Hist.: SDSD 12-2002, f. 12-26-02, cert. ef. 12-28-02; SPD 11-2009, f. 7-31-09, cert. ef. 8-1-09; SPD 20-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-300-0150
Scope and Limitations of Children's Intensive In-Home Services

(1) CIIS are intended to support, not supplant, the natural supports supplied by a primary caregiver. CIIS are not available to replace services provided by a primary caregiver or to replace other governmental or com-

munity services. Regardless of other services available, a primary caregiver must provide a minimum of 40 hours per week of in-home daily care for a child.

(2) CIIS are only authorized to enable a primary caregiver to meet the needs of caring for a child on the ICF/IDD Behavioral Waiver and Community First Choice State Plan. All services funded by the Department must be based on the actual and customary costs related to best practice standards of care for children with similar disabilities.

(3) For an initial or annual Plan of Care that is authorized on or after July 1, 2013, CIIS may include a combination of the following waivered and other Medicaid services based upon the needs of a child as determined by the services coordinator and as consistent with the child's Plan of Care:

(a) Community First Choice State Plan services:

(A) Specialized consultation including behavior consultation as described in section (4) of this rule;

(B) Community nursing services as described in section (5) of this rule;

(C) Environmental accessibility adaptations as described in section (6) of this rule;

(D) In-home daily care as described in section (7) of this rule;

(E) Respite as described in section (8) of this rule;

(F) Specialized equipment and supplies as described in section (9) of this rule;

(G) Chore services as described in section (10) of this rule; and

(H) Transportation as described in section (11) of this rule.

(b) Waivered services:

(A) Family training as described in section (12) of this rule;

(B) Specialized diets as described in section (13) of this rule; and

(C) Translation as described in section (14) of this rule.

(4) SPECIALIZED CONSULTATION — BEHAVIOR CONSULTATION. Behavior consultation is only authorized to support a primary caregiver in their caregiving role. Behavior consultation is only authorized, as needed, to respond to specific problems identified by a primary caregiver or services coordinator. Behavior consultants must:

(a) Work with the primary caregiver to identify:

(A) Areas of a child's family home life that are of most concern for the parent and child;

(B) The formal or informal responses the family or provider has used in those areas; and

(C) The unique characteristics of the family that may influence the responses that may work with the child.

(b) Assess the child. The assessment must include:

(A) Specific identification of the behaviors or areas of concern;

(B) Identification of the settings or events likely to be associated with, or to trigger, the behavior;

(C) Identification of early warning signs of the behavior;

(D) Identification of the probable reasons that are causing the behavior and the needs of the child that are being met by the behavior, including the possibility that the behavior is:

(i) An effort to communicate;

(ii) The result of a medical condition;

(iii) The result of an environmental cause; or

(iv) The symptom of an emotional or psychiatric disorder.

(E) Evaluation and identification of the impact of disabilities (i.e. autism, blindness, deafness, etc.) that impact the development of strategies and affect the child and the area of concern; and

(F) An assessment of current communication strategies.

(c) Develop a variety of positive strategies that assist the primary caregiver and provider to help the child use acceptable, alternative actions to meet the child's needs in the most cost effective manner. These strategies may include changes in the physical and social environment, developing effective communication, and appropriate responses by a primary caregiver and provider to the early warning signs.

(A) Interventions must be done in accordance with positive behavioral theory and practice as defined in OAR 411-300-0110.

(B) The least intrusive intervention possible must be used.

(C) Abusive or demeaning interventions must never be used.

(D) The strategies must be adapted to the specific disabilities of the child and the style or culture of the family.

(d) Develop emergency and crisis procedures to be used to keep the child, primary caregiver, and provider safe. Protective physical intervention must only be utilized in accordance with OAR 411-300-0140.

(e) Develop a written Behavior Support Plan that includes the following:

(A) Use of clear, concrete language that is understandable to the primary caregiver and provider; and

(B) Describes the assessment, strategies, and procedures to be used.

(f) Teach the provider and primary caregiver the strategies and procedures to be used.

(g) Monitor and revise the Behavior Support Plan as needed.

(5) COMMUNITY NURSING SERVICES.

(a) Evaluation and identification of supports that minimize health risks, while promoting the child's autonomy and self-management of healthcare;

(b) Medication reviews;

(c) Collateral contact with the services coordinator regarding the child's community health status to assist in monitoring safety and well-being and to address needed changes to the person-centered Plan of Care; and

(d) Delegation of nursing tasks to a provider and primary caregiver so that caregivers may safely perform health related tasks.

(6) ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS. Environmental accessibility adaptations are physical adaptations to a family home that are necessary to ensure the health, welfare, and safety of the child in the family home due to the child's intellectual or developmental disability or that are necessary to enable the child to function with greater independence around the family home and in family activities.

(a) Environmental accessibility adaptations include but are not limited to:

(A) An environmental modification consultation to determine the appropriate type of adaptation to ensure the health, welfare, and safety of the child;

(B) Installation of shatter-proof windows;

(C) Hardening of walls or doors;

(D) Specialized, hardened, waterproof, or padded flooring;

(E) An alarm system for doors or windows;

(F) Protective covering for smoke detectors, light fixtures, and appliances;

(G) Sound and visual monitoring systems;

(H) Fencing;

(I) Installation of ramps, grab-bars, and electric door openers;

(J) Adaptation of kitchen cabinets and sinks;

(K) Widening of doorways;

(L) Handrails;

(M) Modification of bathroom facilities;

(N) Individual room air conditioners for a child whose temperature sensitivity issues create behaviors or medical conditions that put the child or others at risk;

(O) Installation of non-skid surfaces;

(P) Overhead track systems to assist with lifting or transferring;

(Q) Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the child;

(R) Modifications for the primary vehicle used by the child that are necessary to meet the unique needs of the child and ensure the health, welfare, and safety of the child (lift or interior alterations such as seats, head, and leg rests; and belts, special safety harnesses, or other unique modifications to keep the child safe in the vehicle); and

(S) Adaptations to control lights, heat, stove, etc.

(b) Environmental accessibility adaptations exclude:

(A) Adaptations or improvements to the family home that are of general utility and are not for the direct safety, remedial, or long term benefit to the child;

(B) Adaptations that add to the total square footage of the family home; and

(C) General repair or maintenance and upkeep required for the family home or motor vehicle, including repair of damage caused by the child.

(c) Environmental modifications are limited to $5,000 per modification. A services coordinator may request approval for additional expenditures through the Department prior to expenditure. Approval is based on the child's service needs and goals and the Department's determination of appropriateness and cost-effectiveness.

(d) Environmental modifications must be tied to supporting activities of daily living, instrumental activities of daily living, and health-related tasks as identified in the Plan of Care.

(e) Modifications over $500 must be completed by a state licensed contractor. Any modification requiring a permit must be inspected and be certified as in compliance with local codes by local inspectors and filed in provider file prior to payment. Environmental modifications must be made

within the existing square footage of the family home, except for external ramps, and cannot add to the square footage of the building. Payment to the contractor is to be withheld until the work meets specifications.

(f) Environmental accessibility adaptations that are provided in a rental structure must be authorized in writing by the owner of the structure prior to initiation of the work. This does not preclude any reasonable accommodations required under the Americans with Disabilities Act.

(7) IN-HOME DAILY CARE. In-home daily care services include the purchase of direct provider support provided to a child in the family home or community by qualified individual providers and agencies. Provider assistance provided through in-home daily care must support the child to live as independently as appropriate for the child's age and must be based on the identified needs of the child, supporting the family in a primary caregiving role. Primary caregivers are expected to be present or immediately available during the provision of in-home daily care.

(a) In-home daily care services provided by qualified providers or agencies include:

(A) Basic personal hygiene — Assistance with bathing and grooming;

(B) Toileting, bowel, and bladder care — Assistance in the bathroom, diapering, external cleansing of perineal area, and care of catheters;

(C) Mobility — Transfers, comfort, positioning, and assistance with range of motion exercises;

(D) Nutrition — feeding and monitoring intake and output;

(E) Skin care — Dressing changes;

(F) Physical healthcare including delegated nursing tasks;

(G) Supervision — Providing an environment that is safe and meaningful for the child and interacting with the child to prevent danger to the child and others, and maintain skills and behaviors required to live in the home and community;

(H) Assisting the child with appropriate leisure activities to enhance development in the family home and community and provide training and support in personal environmental skills;

(I) Communication — Assisting the child in communicating, using any means used by the child;

(J) Neurological — Monitoring of seizures, administering medication, and observing status; and

(K) Accompanying the child and family to health related appointments.

(b) In-home daily care services must:

(A) Be previously authorized by the services coordinator before services begin;

(B) Be delivered through the most cost effective method as determined by the services coordinator; and

(C) Only be provided when the child is present to receive services.

(c) In-home daily care services exclude:

(A) Hours that supplant the natural supports and services available from family, community, other government or public services, insurance plans, schools, philanthropic organizations, friends, or relatives;

(B) Hours to allow a primary caregiver to work or attend school;

(C) Support generally provided at the child's age by parents or other family members;

(D) Educational and supportive services provided by schools as part of a free and appropriate education for children and young adults under the Individuals with Disabilities Education Act;

(E) Services provided by the family; and

(F) Home schooling.

(d) In-home daily care services may not be provided on a 24-hour shift-staffing basis. The child's primary caregiver is expected to provide at least 40 hours of care each week and supervise the child each day with the exception of overnight respite. The 40 hours of care and supervision may not include hours when the child's primary caregiver is sleeping.

(8) RESPITE. Respite services are provided to a child on a periodic or intermittent basis furnished because of the temporary absence of, or need for relief of, the primary caregiver.

(a) Respite may include both day and overnight services that may be provided in:

(A) The family home;

(B) A licensed, certified, or otherwise regulated setting;

(C) A qualified provider's home. If overnight respite is provided in a qualified provider's home, the services coordinator and the child's parent must document that the home is a safe setting for the child; or

(D) A disability-related or therapeutic recreational camp.

(b) The services coordinator does not authorize respite services:

(A) To allow primary caregivers to attend school or work;

(B) That are ongoing and occur on more than a periodic schedule, such as eight hours a day, five days a week;

(C) On more than 14 consecutive overnight stays in a calendar month;

(D) For more than 10 days per individual plan year when provided at a specialized camp;

(E) For vacation travel and lodging expenses; or

(F) To pay for room and board if provided at a licensed site or specialized camp.

(9) SPECIALIZED EQUIPMENT AND SUPPLIES. Specialized equipment and supplies include the purchase of devices, aids, controls, supplies, or appliances that are necessary to enable a child to increase the child's abilities to perform and support activities of daily living, or to perceive, control, or communicate with the environment in which the child lives.

(a) Electronic devices to secure assistance in an emergency in the community and other reminders such as medication minders and alert systems for ADL/IADL supports, or mobile electronic devices. Expenditures for electronic devices of more than $500 in a plan year require Department approval.

(b) Assistive technology to provide additional security and replace the need for direct interventions to allow self direction of care and maximize independence. Examples include motion sound sensors, two-way communication systems, automatic faucets and soap dispensers, incontinent and fall sensors, or other electronic backup systems.

(A) Limit of $5000 per year without Department approval.

(B) Any single device or assistance costing more than $500 must be approved by the Department.

(c) Assistive devices. Examples include durable medical equipment, mechanical apparatus, electrical appliance or information technology device to assist and enhance an individual's independence in performing ADL/IADLs, not covered by other Medicaid programs. Limit of $5000 per year without Department approval. Any single device or assistance costing more than $500 must be approved by the department.

(d) The purchase of specialized equipment and supplies may include the cost of a professional consultation, if required, to assess, identify, adapt, or fit specialized equipment. The cost of professional consultation may be included in the purchase price of the equipment.

(e) To be authorized by the services coordinator, specialized equipment and supplies must be:

(A) In addition to any medical equipment and supplies furnished under the Oregon Health Plan and private insurance;

(B) Determined necessary to the daily functions of the child; and

(C) Directly related to a child's disability.

(f) Specialized equipment and supplies exclude:

(A) Items that are not necessary or of direct medical or remedial benefit to the child;

(B) Specialized equipment and supplies intended to supplant similar items furnished under the Oregon Health Plan or private insurance;

(C) Items available through family, community, or other governmental resources;

(D) Items that are considered unsafe for a child;

(E) Toys or outdoor play equipment; and

(F) Equipment and furnishings of general household use.

(g) Funding for specialized equipment with an expected life of more than one year is one time funding that is not continued in subsequent plan years. Specialized equipment may only be included in a child's annual Plan of Care when all other public and private resources for the equipment have been exhausted.

(h) The services coordinator must secure use of equipment or furnishings costing more than $500 through a written agreement between the Department and the child's parent that specifies the time period the item is to be available to the child and the responsibilities of all parties if the item is lost, damaged, or sold within that time period. Any equipment or supplies purchased with CIIS funds that are not used according to the child's annual Plan of Care, or according to the written agreement between the Department and the child's parent, may be immediately recovered.

(10) CHORE SERVICES. Chore services may be provided only in situations where no one else in the household is capable of either performing or paying for the services and no other relative, caregiver, landlord, community, volunteer agency, or third-party payer is capable of or responsible for providing these services

(11) TRANSPORTATION. Non-medical transportation is provided in order to enable a child to gain access to community services, activities, and resources as specified in the child's Plan of Care. Non-medical transportation excludes:

(a) Transportation provided by family members;

(b) Transportation used for behavioral intervention or calming;

(c) Transportation normally provided by schools and by the primary caregiver for children of similar age without disabilities;

(d) Purchase of any family vehicle;

(e) Vehicle maintenance and repair;

(f) Reimbursement for out-of-state travel expenses;

(g) Ambulance services; or

(h) Transportation services that may be obtained through other means such as the Oregon Health Plan or other public or private resources available to the child.

(12) FAMILY TRAINING. Family training services include the purchase of training, coaching, counseling, and support that increase the abilities of a child's family to care for and maintain the child in the family home. Family training services include:

(a) Counseling services that assist the family with the stresses of having a child with an intellectual or developmental disability.

(A) To be authorized, the counseling services must:

(i) Be provided by licensed providers including but not limited to psychologists licensed under ORS 675.030, professionals licensed to practice medicine under ORS 677.100, social workers licensed under ORS 675.530, or counselors licensed under ORS 675.715;

(ii) Directly relate to the child's intellectual or developmental disability and the ability of the family to care for the child; and

(iii) Be short-term.

(B) Counseling services are excluded for:

(i) Therapy that could be obtained through the Oregon Health Plan or other payment mechanisms;

(ii) General marriage counseling;

(iii) Therapy to address the psychopathology of family members;

(iv) Counseling that addresses stressors not directly attributed to the child;

(v) Legal consultation;

(vi) Vocational training for family members; and

(vii) Training for families to carry out educational activities in lieu of school.

(b) Registration fees for organized conferences, workshops, and group trainings that offer information, education, training, and materials about the child's intellectual or developmental disability, medical, or health conditions.

(A) Conferences, workshops, or group trainings must be prior authorized by the services coordinator and include those that:

(i) Directly relate to the child's intellectual or developmental disability; and

(ii) Increase the knowledge and skills of the child's family to care for and maintain the child in the family home.

(B) Conference, workshop, or group training costs exclude:

(i) Registration fees in excess of $500 per family for an individual event;

(ii) Travel, food, and lodging expenses;

(iii) Services otherwise provided under the Oregon Health Plan or available through other resources; or

(iv) Costs for individual family members who are employed to care for the child.

(13) SPECIALIZED DIETS. Specialized diets do not constitute a full nutritional regime.

(a) In order for a specialized diet to be authorized:

(A) The foods must be on the approved list developed by the Department;

(B) The specialized diet must be ordered at least annually by a physician licensed by the Oregon Board of Medical Examiners;

(C) The specialized diet must be periodically monitored by a dietician or physician; and

(D) The specialized diet may not be reimbursed through the Oregon Health Plan or any other source of public and private funding.

(b) Restaurant and prepared foods, vitamins, and supplements are specifically excluded from a specialized diet.

(14) TRANSLATION. If the primary caregiver or the child's primary language is not English, translation service is provided to allow the child or the primary caregiver to communicate with providers of CIIS.

(15) All CIIS authorized by the Department must be included in a written Plan of Care in order to be eligible for payment. The Plan of Care must use the most cost effective services for safely and appropriately meeting a child's service needs.

(16) Service budgets increase or decrease in direct relationship to the increasing or decreasing behavior criteria score.

(17) If the primary caregiver's primary language is not English, cost of interpretation or translation services related to CIIS are not considered part of the child's service budget.

(18) EXCEPTIONS. All exceptions must be authorized by the Department's CIIS manager. Exceptions are limited to 90 days unless reauthorized. Ninety-day exceptions are only authorized in the following circumstances:

(a) A child is at immediate risk of loss of family home without the expenditure;

(b) The expenditure provides supports for a child's emerging or changing care needs or behaviors;

(c) A significant medical condition or event occurs that prevents the primary caregiver from providing care or services as documented by a physician; or

(d) The services coordinator determines, with a behavior consultant, that a child needs two staff present at one time to ensure the safety of the child and others. Prior to approval, the services coordinator must determine that all caregivers, including the child's parents, have been trained in behavior management and that all other feasible recommendations from the behavior consultant and services coordinator have been implemented.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 427.005, 427.007 & 430.215

Hist.: SDSD 12-2002, f. 12-26-02, cert. ef. 12-28-02; SPD 11-2009, f. 7-31-09, cert. ef. 8-1-09; SPD 20-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

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Rule Caption: Long-Term Support for Children with Intellectual or Developmental Disabilities

Adm. Order No.: SPD 21-2013(Temp)

Filed with Sec. of State: 7-1-2013

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Rules Amended: 411-308-0010, 411-308-0020, 411-308-0030, 411-308-0050, 411-308-0060, 411-308-0070, 411-308-0080, 411-308-0100, 411-308-0120

Subject: The Department of Human Services (Department) is immediately amending the long-term support rules for children with intellectual or developmental disabilities in OAR chapter 411, division 308 to:

Reflect new definitions applicable to Community First Choice State Plan services;

Specify the eligibility requirements to reflect changes made as a result of the Community First Choice State Plan;

Clarify hearing rights;

Describe and coincide with the services available in the Community First Choice State Plan and Home and Community-Based Waiver amendments;

Require a functional needs assessment as part of a child's service planning process; and

Clarify the responsibilities of a services coordinator when developing a child's Plan of Care.

Rules Coordinator: Christina Hartman—(503) 945-6398

411-308-0010

Statement of Purpose and Principles

(1) The rules in OAR chapter 411, division 308 prescribe standards, responsibilities, and procedures for providing in home support for children with intellectual or developmental disabilities to prevent out-of-home placement, or to return a child with an intellectual or developmental disability back to the family home from a residential setting other than the child's family home.

(2) Long-term supports are designed to increase a family's ability to care for a child with an intellectual or developmental disability in the family home. Long-term supports may resolve a crisis by providing supports to prevent the need for the child to be placed or remain in a residential setting other than the child's family home.

Stat. Auth.: ORS 409.050 & 410.070

Stats. Implemented: ORS 427.005, 427.007 & 430.610 - 430.670

Hist.: SPD 7-2009(Temp), f. & cert. ef. 7-1-09 thru 12-28-09; SPD 20-2009, f. 12-23-09, cert. ef. 12-28-09; SPD 21-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-308-0020
Definitions

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 308:

(1) "Abuse" means abuse of a child as defined in ORS 419B.005.

(2) "Activities of Daily Living (ADL)" mean those personal, functional activities required by a child for continued well-being that are essential for health and safety.

(3) "Annual Support Plan" means the written details of the supports, activities, and resources required for a child to achieve personal outcomes and be supported by the family in the family home. A child's support needs are identified through a functional needs assessment. The manner in which services are delivered, service providers, and the frequency of services are reflected in an Annual Support Plan. The Annual Support Plan is developed at minimum annually to reflect decisions and agreements made during a person-centered process of planning and information gathering. A child's Annual Support Plan is the only plan of care required by the Department for a child receiving long-term supports.

(4) "Behavior Consultant" means a contractor with specialized skills who develops a Behavior Support Plan.

(5) "Behavior Support Plan (BSP)" means a written strategy based on person-centered planning and a functional assessment that outlines specific instructions for a provider to follow, to cause a child's challenging behaviors to become unnecessary, and to change the provider's own behavior, adjust environment, and teach new skills.

(6) "Behavior Support Services" mean services that are provided to assist with behavioral challenges due to a child's intellectual or developmental disability that prevents the child from accomplishing activities of daily living, instrumental activities of daily living, and health related tasks.

(7) "Case Management" means an organized service to assist individuals to select, obtain, and utilize resources and services.

(8) "CDDP" means "Community Developmental Disability Program" as defined in this rule.

(9) "Child" means an individual under the age of 18 applying for or determined eligible for long-term support.

(10) "Children's Intensive In-Home Services" mean the services described in:

(a) OAR chapter 411, division 300, Children's Intensive In-Home Services, Behavior Program;

(b) OAR chapter 411, division 350, Medically Fragile Children Services; or

(c) OAR chapter 411, division 355, Medically Involved Children's Program.

(11) "Chore Services" mean the services described in OAR 411-308-0120 needed to maintain a clean, sanitary, and safe environment in a child's home. Chore services include heavy household chores such as washing floors, windows, and walls, tacking down loose rugs and tiles, and moving heavy items of furniture for safe access and egress. Chore services may include yard hazard abatement to ensure the outside of the home is safe for the child to traverse and enter and exit the home.

(12) "Community Developmental Disability Program (CDDP)" means the entity that is responsible for the planning and delivery of services for children with intellectual or developmental disabilities according to OAR chapter 411, division 320. A CDDP operates in a specific geographic service area of the state under a contract with the Department, local mental health authority, or other entity as contracted by the Department.

(13) "Community First Choice State Plan" means Oregon's state plan amendment authorized under section 1915(k) of the Social Security Act.

(14) "Community Nursing Services" mean the services described in OAR 411-308-0120 that include nurse delegation and care coordination for a child living in his or her own home. Community nursing services do not include direct nursing care and are not covered by other Medicaid spending authorities

(15) "Cost Effective" means that a specific service or support meets a child's service needs and costs less than, or is comparable to, other service options considered.

(16) "CPMS" means the Client Processing Monitoring System.

(17) "Crisis" means the risk factors described in OAR 411-320-0160 are present for which no appropriate alternative resources are available and a child meets the eligibility requirements for crisis diversion services in OAR 411-320-0160.

(18) "Department" means the Department of Human Services (DHS). The term "Department" is synonymous with "Seniors and People with Disabilities Division (Division)".

(19) "Developmental Disability" means a neurological condition that originates in the developmental years, that is likely to continue, and significantly impacts adaptive behavior as diagnosed and measured by a qualified professional as described in OAR 411-320-0080.

(20) "Director" means the Director of the Department's Office of Developmental Disability Services, or the Director's designee. The term "Director" is synonymous with "assistant director" and "administrator".

(21) "Employer-Related Supports" mean activities that assist a family with directing and supervising provision of services described in a child's Annual Support Plan. Supports to a family assuming the role of employer include but are not limited to:

(a) Education about employer responsibilities;

(b) Orientation to basic wage and hour issues;

(c) Use of common employer-related tools such as job descriptions; and

(d) Fiscal intermediary services.

(22) "Environmental Accessibility Adaptations" mean the physical adaptations as described in OAR 411-308-0120 that are necessary to ensure the health, welfare, and safety of a child in the home, or that enable the child to function with greater independence in the home.

(23) "Exit" means termination or discontinuance of long-term support.

(24) "Family"

(a) Means a unit of two or more persons that includes at least one child with an intellectual or developmental disability where the primary caregiver is:

(A) Related to the child with an intellectual or developmental disability by blood, marriage, or legal adoption; or

(B) In a domestic relationship where partners share:

(i) A permanent residence;

(ii) Joint responsibility for the household in general (e.g. child-rearing, maintenance of the residence, basic living expenses); and

(iii) Joint responsibility for supporting the child when the child with an intellectual or developmental disability is related to one of the partners by blood, marriage, or legal adoption.

(b) The term "family" is defined as described above for purposes of:

(A) Determining a child's eligibility for long-term supports as a resident in the family home;

(B) Identifying persons who may apply, plan, and arrange for individual supports; and

(C) Determining who may receive family training.

(25) "Family Home" means a child's primary residence that is not under contract with the Department to provide services as a licensed, endorsed, or certified foster home, residential care facility, assisted living facility, nursing facility, or other residential support program site.

(26) "Family Training" means training and counseling services for the family of a child that increase the family's capacity to care for, support, and maintain the child in the home as described in OAR 411-308-0120. Family training includes:

(a) Instruction about treatment regimens and use of equipment specified in the child's Annual Support Plan;

(b) Information, education, and training about the child's intellectual or developmental disability, medical, or behavioral conditions; and

(c) Counseling for the family to relieve the stress associated with caring for a child with an intellectual or developmental disability.

(27) "Fiscal Intermediary" means a person or entity that receives and distributes long-term support funds on behalf of the family of an eligible child according to the child's Annual Support Plan.

(28) "Founded Reports" means the Department's Children, Adults, and Families Division or Law Enforcement Authority (LEA) determination, based on the evidence, that there is reasonable cause to believe that conduct in violation of the child abuse statutes or rules has occurred and such conduct is attributable to the person alleged to have engaged in the conduct.

(29) "Functional Needs Assessment (FNAT)" means an assessment that documents the level of need, accommodates a child's participation in service planning, and includes --

(a) Completing a comprehensive and holistic assessment;

(b) Surveying physical, mental, and social functioning; and

(c) Identifying risk factors, choices and preferences, and service needs.

(30) "General Business Provider" means an organization or entity selected by the parent or guardian of an eligible child, and paid with long-term support funds that:

(a) Is primarily in business to provide the service chosen by the child's parent or guardian to the general public;

(b) Provides services for the child through employees, contractors, or volunteers; and

(c) Receives compensation to recruit, supervise, and pay the persons who actually provide support for the child.

(31) "Guardian" means a person or agency appointed and authorized by a court to make decisions about services for a child.

(32) "Home and Community-Based Waivered Services" mean the services approved by the Centers for Medicare and Medicaid Services in accordance with Section 1915(c) and 1115 of the Social Security Act.

(33) "Incident Report" means the written report of any injury, accident, act of physical aggression, or unusual incident involving a child.

(34) "Independent Provider" means a person selected by a child's parent or guardian and paid with long-term support funds to personally provide services to the child.

(35) "Individual" means a child with an intellectual or developmental disability applying for or determined eligible for developmental disability services.

(36) "In-Home Daily Care (IHDC)" means Medicaid state plan funded essential supportive daily care as described in OAR 411-308-0120 that is delivered by a qualified provider that enables a child to remain in, or return to, the family home.

(37) "Instrumental Activities of Daily Living (IADL)" mean those activities, other than activities of daily living, required to continue independent living.

(38) "Intellectual Disability" has the meaning set forth in OAR 411-320-0020 and described in OAR 411-320-0080.

(39) "Level of Care" means an assessment completed by a services coordinator has determined a child meets institutional level of care. A child meets institutional level of care for an intermediate care facility for individuals with intellectual or developmental disabilities if:

(a) The child has a condition of an intellectual disability or a developmental disability as defined in OAR 411-320-0020 and meets the eligibility criteria for developmental disability services as described in OAR 411-320-0080; and

(b) The child has a significant impairment in one or more areas of adaptive functioning. Areas of adaptive functioning include self direction, self care, home living, community use, social, communication, mobility, or health and safety.

(40) "Long-Term Support" means individualized planning and service coordination, arranging for services to be provided in accordance with Annual Support Plans, and purchase of supports that are not available through other resources that are required for children with intellectual or developmental disabilities who are eligible for long term support services to live in the family home. Long-term supports are designed to:

(a) Prevent unwanted out-of-home placement and maintain family unity; and

(b) Whenever possible, reunite families with children with intellectual or developmental disabilities who have been placed out of the home.

(41) "Long-Term Support Funds" mean public funds contracted by the Department to the community developmental disability program (CDDP) and managed by the CDDP to assist families with the identification and selection of supports for children with intellectual or developmental disabilities according to the child's Annual Support Plan..

(42) "Mandatory Reporter" means any public or private official as defined in OAR 407-045-0260 who comes in contact with and has reasonable cause to believe a child with or without an intellectual or developmental disability has suffered abuse, or comes in contact with any person whom the official has reasonable cause to believe abused a child, regardless of whether or not the knowledge of the abuse was gained in the reporter's official capacity. Nothing contained in ORS 40.225 to 40.295 affects the duty to report imposed by this section, except that a psychiatrist, psychologist, clergy, attorney, or guardian ad litem appointed under ORS 419B.231 is not required to report such information communicated by a person if the communication is privileged under ORS 40.225 to 40.295.

(43) "Natural Supports" or "Natural Support System" means the resources available from relatives, friends, significant others, neighbors, roommates, and the community. Services provided by natural supports are resources that are not paid for by the Department.

(44) "Nurse" means a person who holds a current license from the Oregon Board of Nursing as a registered nurse or licensed practical nurse pursuant to ORS chapter 678.

(45) "Nursing Care Plan" means the plan of care developed by a nurse that describes the medical, nursing, psychosocial, and other needs of a child and how those needs are met. The Nursing Care Plan includes the tasks that are taught or delegated to a qualified provider or the child's family.

(46) "OHP" means the Oregon Health Plan.

(47) "Oregon Intervention System (OIS)" means a system of providing training to people who work with designated individuals to intervene physically or non-physically to keep individuals from harming self or others. OIS is based on a positive approach that includes methods of effective evasion, deflection, and escape from holding.

(48) "OSIP-M" means Oregon Supplemental Income Program-Medical as defined in OAR 461-101-0010. OSIP-M is Oregon Medicaid insurance coverage for those who meet the eligibility criteria as described in OAR chapter 461.

(49) "Person-Centered Planning" means:

(a) A process, either formal or informal, for gathering and organizing information that helps:

(A) Determine and describe choices about personal goals, activities, and lifestyle preferences;

(B) Design strategies and networks of support to achieve goals and a preferred lifestyle using strengths, relationships, and resources; and

(C) Identify, use, and strengthen naturally occurring opportunities for support at home and in the community.

(b) The methods for gathering information vary, but all are consistent with a child's needs and preferences.

(50) "Personal Care Services" means assistance with activities of daily living, instrumental activities of daily living, and health-related tasks through cueing, monitoring, reassurance, redirection, set-up, hands-on, standby assistance, and reminding.

(51) "Plan Year" means twelve consecutive months from the start date specified on a child's authorized Annual Support Plan.

(52) "Positive Behavioral Theory and Practice" means a proactive approach to behavior and behavior interventions that:

(a) Emphasizes the development of functional alternative behavior and positive behavior intervention;

(b) Uses the least intervention possible;

(c) Ensures that abusive or demeaning interventions are never used; and

(d) Evaluates the effectiveness of behavior interventions based on objective data.

(53) "Protective Physical Intervention (PPI)" means any manual physical holding of, or contact with, a child that restricts the child's freedom of movement. The term "protective physical intervention" is synonymous with "physical restraint".

(54) "Provider Organization" means an entity selected by a child's parent or guardian and paid with long-term support funds that:

(a) Is primarily in business to provide supports for individuals with intellectual or developmental disabilities;

(b) Provides supports for the child through employees, contractors, or volunteers; and

(c) Receives compensation to recruit, supervise, and pay the persons who actually provide support for the child.

(55) "Quality Assurance" means a systematic procedure for assessing the effectiveness, efficiency, and appropriateness of services.

(56) "Regional Process" means a standardized set of procedures through which a child's Annual Support Plan and funding to implement the Annual Support Plan are reviewed for approval. The regional process includes review of the potential risk of out-of-home placement, the appropriateness of the proposed supports, and cost effectiveness of the Annual Support Plan.

(57) "Respite" means intermittent services as described in OAR 411-308-0120 provided on a periodic basis, but not more than 14 consecutive days, for the relief of, or due to the temporary absence of, a person normally providing supports to a child with an intellectual or developmental disability unable to care for him or herself.

(58) "Services Coordinator" means an employee of the community developmental disability program or other agency that contracts with the county or Department, who plans, procures, coordinates, and monitors long-term support, and acts as a proponent for children with intellectual or developmental disabilities and their families.

(59) "Specialized Equipment and Supplies" mean devices, aids, controls, supplies, or appliances as described in OAR 411-308-0120 that meet applicable standards of manufacture, design, and installation that enables a child to increase the child's abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. Specialized equipment and supplies do not include items not of direct benefit to a child.

(60) "Substantiated" means an abuse investigation has been completed by the Department or the Department's designee and the preponderance of the evidence establishes the abuse occurred.

(61) "Supplant" means take the place of.

(62) "Support" means the assistance that a child and the child's family require, solely because of the effects of and intellectual or developmental disability, to maintain or increase the child's age-appropriate independence, achieve a child's age-appropriate community presence and participation, and to maintain the child in the family home. Support is subject to change with time and circumstances.

(63) "Transportation" means services as described in OAR 411-308-0120 that allow a child to gain access to community services, activities, and resources that are not medical in nature.

(64) "These Rules" mean the rules in OAR chapter 411, division 308.

(65) "Volunteer" means any person providing services without pay to support the services provided to a child.

Stat. Auth.: ORS 409.050 & 410.070

Stats. Implemented: ORS 427.005, 427.007, 430.610 - 430.670

Hist.: SPD 7-2009(Temp), f. & cert. ef. 7-1-09 thru 12-28-09; SPD 20-2009, f. 12-23-09, cert. ef. 12-28-09; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 5-2010, f. 6-29-10, cert. ef. 7-1-10; SPD 4-2011(Temp), f. & cert. ef. 2-1-11 thru 7-31-11; SPD 20-2011, f. & cert. ef. 8-1-11; SPD 21-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-308-0030

Long-Term Support Administration and Operation

(1) FISCAL INTERMEDIARY SERVICES. The CDDP must provide, or arrange a third party to provide, fiscal intermediary services for all families. The fiscal intermediary receives and distributes long-term support funds on behalf of the family. The responsibilities of the fiscal intermediary include payments to vendors as well as all activities and records related to payroll and payment of employer-related taxes and fees as an agent of families who employ persons to provide services, supervision, or training in the family home or community. In this capacity, the fiscal intermediary may not recruit, hire, supervise, evaluate, dismiss, or otherwise discipline employees.

(2) GENERAL RECORD REQUIREMENTS.

(a) CONFIDENTIALITY. The CDDP must maintain records of services to individuals in accordance with OAR 411-320-0070, ORS 179.505, ORS 192.515 to 192.518, 45 CFR 205.50, 45 CFR 164.512, Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2 HIPAA, and any Department administrative rules and policies pertaining to service records.

(b) DISCLOSURE. For the purpose of disclosure from medical records under these rules, CDDPs are considered "providers" as defined in ORS 179.505(1) and ORS 179.505 is applicable.

(A) Access to records by the Department does not require authorization by the family.

(B) For the purposes of disclosure from non-medical records, all or portions of the information contained in the non-medical record may be exempt from public inspection under the personal privacy information exemption to the public records law set forth in ORS 192.502(2).

(c) INDIVIDUAL RECORDS. Records for children who receive long-term support must be kept up-to-date and must include:

(A) An easily-accessed summary of basic information as described in OAR 411-320-0070 including date of enrollment in long-term support;

(B) Records related to receipt and disbursement of long-term support funds, including expenditure authorizations, expenditure verification, copies of CPMS expenditure reports, verification that providers meet requirements of OAR 411-308-0130, and documentation of family acceptance or delegation of record keeping responsibilities outlined in this rule. Records must include:

(i) Itemized invoices and receipts to record purchase of any single item;

(ii) Signed contracts and itemized invoices for any services purchased from independent contractors and professionals;

(iii) Written professional support plans, assessments, and reviews to document acceptable provision of behavior support, nursing, and other professional training and consultation services; and

(iv) Pay records, including timesheets signed by both employee and employer, to record employee services.

(C) Incident reports, including those involving CDDP staff;

(D) Assessments used to determine required supports, preferences, and resources;

(E) When a child is not Medicaid eligible, documentation of the child's eligibility for crisis services and approval of the child's Annual Support Plan through a regional process;

(F) The child's Annual Support Plan and reviews;

(G) The services coordinator's correspondence and notes related to plan development and outcomes; and

(H) Family satisfaction information.

(d) GENERAL FINANCIAL POLICIES AND PRACTICES. The CDDP must:

(A) Maintain up-to-date accounting records consistent with generally accepted accounting principles that accurately reflect all long-term support revenue by source, all expenses by object of expense, and all assets, liabilities, and equities; and

(B) Develop and implement written statements of policy and procedure as are necessary and useful to assure compliance with any Department administrative rule pertaining to fraud and embezzlement.

(e) RECORDS RETENTION. Records must be retained in accordance with OAR chapter 166, division 150, Secretary of State, Archives Division.

(A) Financial records, supporting documents, statistical records, and all other records (except individual records) must be retained for a minimum of three years after the close of the contract period, or until audited.

(B) Individual records must be kept for a minimum of seven years.

(3) COMPLAINTS AND APPEALS. The CDDP must provide for review of complaints and appeals by or on behalf of children related to long-term support as set forth in OAR 411-320-0170.

(4) DENIAL, TERMINATION, SUSPENSION, OR REDUCTION OF SERVICES FOR MEDICAID RECIPIENTS.

(a) Each time the CDDP takes an action to deny, terminate, suspend, or reduce a child's access to services covered under Medicaid, the CDDP must notify the child's parent or guardian of the right to a hearing and the method to request a hearing. The CDDP must mail the notice by certified mail, or personally serve the notice to the child's parent or guardian 10 days or more prior to the effective date of an action.

(A) The CDDP must use form SDS 0947, Notification of Planned Action, or a comparable Department-approved form for such notification.

(B) This notification requirement does not apply if an action is part of, or fully consistent with the child's Annual Support Plan, and the child's parent or guardian has agreed with the action by signing the Annual Support Plan.

(b) A notice required by subsection (a) of this section must include:

(A) The action the CDDP intends to take;

(B) The reasons for the intended action;

(C) The specific Oregon Administrative Rules that support, or the change in federal or state law that requires, the action;

(D) The appealing party's right to request a hearing in accordance with OAR chapter 137, ORS chapter 183, and 42 CFR Part 431, Subpart E;

(E) A statement that the CDDP files on the subject of the hearing automatically becoming part of the hearing record upon default for the purpose of making a prima facie case;

(F) A statement that the actions specified in the notice take effect by default if a Department representative does not receive a request for hearing within 45 days from the date that the CDDP mails or personally serves the notice of action;

(G) In cases of an action based upon a change in law, the circumstances under which a hearing is granted; and

(H) An explanation of the circumstances under which CDDP services are continued if a hearing is requested.

(c) If a child's parent or guardian disagrees with a decision or proposed action by the CDDP to deny, terminate, suspend, or reduce the child's access to services covered under Medicaid, the party may request a hearing as provided in ORS chapter 183. The request for a hearing must be in writing on form DHS 443 and signed by the child's parent or guardian. The signed form (DHS 443) must be received by the Department within 45 days from the date the CDDP mailed the notice of action.

(d) A child's parent or guardian may request an expedited hearing if the child's parent or guardian feels that there is an immediate, serious threat to the child's life or health should the normal timing of the hearing process be followed.

(e) If a child's parent or guardian requests a hearing before the effective date of the proposed action and requests that the existing services be continued, the Department shall continue the services.

(A) The Department must continue the services until whichever of the following occurs first:

(i) The current authorization expires;

(ii) The administrative law judge issues a proposed order and the Department issues a final order; or

(iii) The child is no longer eligible for Medicaid benefits.

(B) The Department must notify the child's parent or guardian that the Department is continuing the service. The notice must inform the child's parent or guardian that, if the hearing is resolved against the child, the Department may recover the cost of any services continued after the effective date of the continuation notice.

(f) The Department may reinstate services if:

(A) The Department takes an action without providing the required notice and the child's parent or guardian requests a hearing;

(B) The Department fails to provide the notice in the time required in this rule and the child's parent or guardian requests a hearing within 10 days of the mailing of the notice of action; or

(C) The post office returns mail directed to the child's parent or guardian, but the location of the child's parent or guardian becomes known during the time that the child is still eligible for services.

(g) The Department must promptly correct the action taken up to the limit of the original authorization, retroactive to the date the action was taken, if the hearing decision is favorable to the child, or the Department decides in the child's favor before the hearing.

(h) The Department representative and the child's parent or legal guardian may have an informal conference, without the presence of the administrative law judge, to discuss any of the matters listed in OAR 137-003-0575. The informal conference may also be used to:

(A) Provide an opportunity for the Department and the child's parent or guardian to settle the matter;

(B) Ensure the child's parent or guardian understands the reason for the action that is the subject of the hearing request;

(C) Give the child's parent or guardian an opportunity to review the information that is the basis for that action;

(D) Inform the child's parent or guardian of the rules that serve as the basis for the contested action;

(E) Give the child's parent or guardian and the Department the chance to correct any misunderstanding of the facts;

(F) Determine if the child's parent or guardian wishes to have any witness subpoenas issued; and

(G) Give the Department an opportunity to review its action or the action of the CDDP.

(i) The child's parent or guardian may, at any time prior to the hearing date, request an additional conference with the Department representative. At the Department representative's discretion, the Department representative may grant an additional conference if it facilitates the hearing process.

(j) The Department may provide the child's parent or guardian the relief sought at any time before the final order is issued.

(k) The child's parent or guardian may withdraw a hearing request at any time prior to the issuance of a final order. The withdrawal is effective on the date the Department or the Office of Administrative Hearings receives the withdrawal. The Department must issue a final order confirming the withdrawal to the last known address of the child's parent or guardian. The child's parent or guardian may cancel the withdrawal up to 10 working days following the date the final order is issued.

(l) Proposed and final orders.

(A) In a contested case, the administrative law judge must serve a proposed order to the child's parent or guardian and the Department.

(B) If the administrative law judge issues a proposed order that is adverse to the child, the child's parent or guardian may file exceptions to the proposed order to be considered by the Department. The exception must be in writing and must be received by the Department no later than 10 days after service of the proposed order. The child's parent or guardian may not submit additional evidence after this period unless the Department grants prior approval.

(C) After receiving the exceptions, if any, the Department may adopt the proposed order as the final order or may prepare a new order. Prior to issuing the final order, the Department may issue an amended proposed order.

(5) OTHER OPERATING POLICIES AND PROCEDURES. The CDDP must develop and implement such written statements of policy and procedure, in addition to those specifically required by this rule, as are necessary and useful to enable the CDDP to accomplish its objectives and to meet the requirements of these rules and other applicable standards and rules.

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 427.005, 427.007, & 430.610 - 430.670
Hist.: SPD 7-2009(Temp), f. & cert. ef. 7-1-09 thru 12-28-09; SPD 20-2009, f. 12-23-09, cert. ef. 12-28-09; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 5-2010, f. 6-29-10, cert. ef. 7-1-10; SPD 21-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-308-0050
Financial Limits of Long-Term Support

(1) In any plan year, support must be limited to the amount of support determined to be necessary by a functional needs assessment and specified in a child's Annual Support Plan. For a child who is not Medicaid eligible, the amount of support specified in the child's Annual Support Plan may not exceed the maximum allowable monthly plan amount published in the Department's rate guidelines in any month during the plan year.

(2) Payment rates used to establish the limits of financial assistance for specific service in the child's Annual Support Plan must be based on the Department's rate guidelines for costs of frequently-used services. Department rate guidelines notwithstanding, final costs may not exceed local usual and customary charges for these services as evidenced by the CDDP's own documentation.

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 427.005, 427.007, 430.610 - 430.670
Hist.: SPD 7-2009(Temp), f. & cert. ef. 7-1-09 thru 12-28-09; SPD 20-2009, f. 12-23-09, cert. ef. 12-28-09; SPD 4-2011(Temp), f. & cert. ef. 2-1-11 thru 7-31-11; SPD 20-2011, f. & cert. ef. 8-1-11; SPD 21-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-308-0060
Eligibility for Long-Term Support

(1) STANDARD ELIGIBILITY. In order to be eligible for long-term support, a child must:

(a) Be under the age of 18;

(b) Be eligible for OSIP-M;

(c) Be determined eligible for developmental disability services by the CDDP of the child's county of residence as described in OAR 411-320-0080; and

(d) After completion of an assessment, meet the level of care as defined in OAR 411-308-0020.

(2) CRISIS ELIGIBILITY. When standard eligibility criteria are not met, the CDDP of a child's county of residence may find a child eligible for long-term support when the child:

(a) Is experiencing a crisis as defined in OAR 411-308-0020 and may be safely served in the family home;

(b) Has exhausted all appropriate alternative resources, including but not limited to natural supports and children's intensive in-home services as defined in OAR 411-308-0020;

(c) Does not receive or may stop receiving other Department-paid in-home or community living services other than state Medicaid plan services, adoption assistance, or short-term assistance, including crisis services provided to prevent out-of-home placement; and

(d) Is at risk of out-of-home placement and requires long-term support to be maintained in the family home; or

(e) Resides in a Department-paid residential service and requires long-term support to return to the family home.

(3) CONCURRENT ELIGIBLITY. Children are not eligible for long-term support from more than one CDDP unless the concurrent service:

(a) Is necessary to transition from one county to another with a change of residence;

(b) Is part of a collaborative plan developed by both CDDPs; and

(c) Does not duplicate services and expenditures.

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 427.005, 427.007, & 430.610 - 430.670
Hist.: SPD 7-2009(Temp), f. & cert. ef. 7-1-09 thru 12-28-09; SPD 20-2009, f. 12-23-09, cert. ef. 12-28-09; SPD 4-2011(Temp), f. & cert. ef. 2-1-11 thru 7-31-11; SPD 20-2011, f. & cert. ef. 8-1-11; SPD 21-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-308-0070
Long-Term Support Entry, Duration, and Exit

(1) ENTRY. An eligible child may enter long-term support when long-term support needs are assessed through an FNAT. Long-term supports must be authorized on an annual basis, prior to the beginning of a new Annual Support Plan.

(2) DURATION OF SERVICES. Once a child has entered long-term support, the child and family may continue receiving long-term supports from the CDDP through the last day of the month during which the child turns 18, as long as the supports continue to be necessary to prevent out-of-home placement, the child remains eligible for long-term support, and long-term support funds are available at the CDDP and authorized by the Department to continue services. The child's Annual Support Plan must be developed each year and kept current.

(3) CHANGE IN SUPPORTS. All increases in the child's Annual Support Plan, excluding statewide cost of living increases, must be approved through a regional process. Redirection of more than 25 percent of the long-term support funds in the child's Annual Support Plan to pur-

chase different supports than those originally authorized must be approved through a regional process.

(4) CHANGE OF COUNTY OF RESIDENCE. If a child and family move outside the CDDP's area of service, the originating CDDP must arrange for services purchased with long-term support funds to continue, to the extent possible, in the new county of residence. The originating CDDP must:

(a) Provide information about the need to apply for services in the new CDDP and assist the family with application for services if necessary; and

(b) Contact the new CDDP to negotiate the date on which the long-term support, including responsibility for payments, shall transfer to the new CDDP.

(5) EXIT. A child must leave a CDDP's long-term support:

(a) When the child no longer resides in the family home;

(b) At the written request of the child's parent or guardian to end the long-term supports;

(c) When the long-term supports are no longer necessary to prevent out-of-home placement due to either;

(A) The risk of out of home placement no longer exists due to changes in either the child's support needs or the family's ability to provide the support; or

(B) Appropriate alternative resources become available, including but not limited to supports through children's intensive in-home services as defined in OAR 411-308-0020.

(d) At the end of the last day of the month during which the child turns 18;

(e) When the child and family moves to a county outside the CDDP's area of service, unless transition services have been previously arranged and authorized by the CDDP as required in section (4) of this rule; or

(f) No less than 30 days after the CDDP has served written notice, in the language used by the family, of intent to terminate services because:

(A) The child's family either cannot be located or has not responded to repeated attempts by CDDP staff to complete the child's Annual Support Plan development and monitoring activities and does not respond to the notice of intent to terminate; or

(B) The CDDP has sufficient evidence that the family has engaged in fraud or misrepresentation, failed to use resources as agreed upon in the child's Annual Support Plan, refused to cooperate with documenting expenses, or otherwise knowingly misused public funds associated with long-term support.

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 427.005, 427.007, & 430.610 - 430.670
Hist.: SPD 7-2009(Temp), f. & cert. ef. 7-1-09 thru 12-28-09; SPD 20-2009, f. 12-23-09, cert. ef. 12-28-09; SPD 4-2011(Temp), f. & cert. ef. 2-1-11 thru 7-31-11; SPD 20-2011, f. & cert. ef. 8-1-11; SPD 21-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-308-0080
Annual Support Plan

(1) The CDDP must provide or arrange for an annual planning process to assist families in establishing outcomes, determining needs, planning for supports, and reviewing and redesigning support strategies for all children eligible for long-term support. The planning process must occur in a manner that:

(a) Identifies and applies existing abilities, relationships, and resources while strengthening naturally occurring opportunities for support at home and in the community;

(b) Is consistent in both style and setting with the child's and family's needs and preferences, including but not limited to informal interviews, informal observations in home and community settings, or formally structured meetings; and

(c) Includes completing an FNAT using a person-centered planning approach.

(2) The CDDP, the child (as appropriate), and the child's family must develop a written Annual Support Plan for the child as a result of the planning process prior to purchasing supports with long-term support funds and annually thereafter. The child's Annual Support Plan must include but not be limited to:

(a) The eligible child's legal name and the name of the child's parent (if different than the child's last name), or the name of the child's guardian;

(b) A description of the supports required, including the reason the support is necessary. For an initial or annual support plan that is authorized after July 1, 2013, the description must be consistent with the FNAT;

(c) Beginning and end dates of the plan year as well as when specific activities and supports are to begin and end;

(d) A list of personal, community, and public resources that are available to the child and how the resources may be applied to provide the required supports. Sources of support may include waivered or state plan services, state general funds, or natural supports.

(e) The type of provider, quantity, frequency, and per unit cost of supports to be purchased with long-term support funds;

(f) Total annual cost of supports;

(g) The schedule of the child's Annual Support Plan reviews; and

(h) Signatures of the child's services coordinator, the child's parent or guardian, and the child (as appropriate).

(3) The child's Annual Support Plan or records supporting development of each child's Annual Support Plan must include evidence that:

(a) When the child is not Medicaid eligible, long-term support funds may only be used to purchase goods or services necessary to prevent the child from out-of-home placement, or to return the child from a community placement to the family home;

(b) The services coordinator has assessed the availability of other means for providing the supports before using long-term support funds, and other public, private, formal, and informal resources available to the child have been applied and new resources have been developed whenever possible;

(c) Basic health and safety needs and supports have been addressed including but not limited to identification of risks including risk of serious neglect, intimidation, and exploitation;

(d) Informed decisions by the child's parent or guardian regarding the nature of supports or other steps taken to ameliorate any identified risks; and

(e) Education and support for the child and the child's family to recognize and report abuse.

(4) The services coordinator must obtain and attach a Nursing Care Plan to the child's written Annual Support Plan when long-term support funds are used to purchase care and services requiring the education and training of a nurse.

(5) The services coordinator must obtain and attach a Behavior Support Plan to the child's written Annual Support Plan when the Behavior Support Plan is implemented by the child's family or providers during the plan year.

(6) Long-term supports may only be provided after the child's Annual Support Plan is developed as described in this rule, authorized by the CDDP, and signed by the child's parent or guardian.

(7) The services coordinator must review and reconcile receipts and records of purchased supports authorized by the child's Annual Support Plan and subsequent Annual Support Plan documents, at least quarterly during the plan year.

(8) At least annually, the services coordinator must conduct and document reviews of the child's Annual Support Plan and resources with the child's family as follows:

(a) Evaluate progress toward achieving the purposes of the child's Annual Support Plan;

(b) Record actual long-term support fund costs;

(c) Note effectiveness of purchases based on services coordinator observation as well as family satisfaction; and

(d) Determine whether changing needs or availability of other resources have altered the need for specific supports or continued use of long-term support funds to purchase supports. This must include a review of the child's continued risk for out-of-home placement and the availability of alternate resources, including eligibility for children's intensive in-home services as defined in OAR 411-308-0020.

(9) When the family and eligible child move to a county outside the area of service, the originating CDDP must assist long-term support recipients by:

(a) Continuing long-term support fund payments authorized by the child's Annual Support Plan which is current at the time of the move, if the support is available, until the transfer date agreed upon according to OAR 411-308-0070; and

(b) Transferring the unexpended portion of the child's long-term support funds to the new CDDP of residence.

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 427.005, 427.007, & 430.610 - 430.670
Hist.: SPD 7-2009(Temp), f. & cert. ef. 7-1-09 thru 12-28-09; SPD 20-2009, f. 12-23-09, cert. ef. 12-28-09; SPD 4-2011(Temp), f. & cert. ef. 2-1-11 thru 7-31-11; SPD 20-2011, f. & cert. ef. 8-1-11; SPD 21-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-308-0100
Conditions for Long-Term Support Purchases

(1) A CDDP must only use long-term support funds to assist families to purchase supports for the purpose defined in OAR 411-308-0010 and in

accordance with the child's Annual Support Plan that meets the requirements for development and content in OAR 411-308-0080.

(2) The CDDP must arrange for supports purchased with long-term support funds to be provided:

(a) In settings and under purchasing arrangements and conditions that allow the family to choose to receive supports and services from another qualified provider;

(b) In a manner consistent with positive behavioral theory and practice and where behavior intervention is not undertaken unless the behavior:

(A) Represents a risk to health and safety of the child or others;

(B) Is likely to continue and become more serious over time;

(C) Interferes with community participation;

(D) Results in damage to property; or

(E) Interferes with learning, socializing, or vocation.

(c) In accordance with applicable state and federal wage and hour regulations in the case of personal services, training, and supervision;

(d) In accordance with applicable state or local building codes in the case of environmental accessibility adaptations to the family home;

(e) In accordance with Oregon Board of Nursing rules in OAR chapter 851 when services involve performance of nursing services or delegation, teaching, and assignment of nursing tasks; and

(f) In accordance with to OAR 411-308-0130 governing provider qualifications.

(3) When long-term support funds are used to purchase services, training, supervision, or other personal assistance for children, the CDDP must require and document that providers are informed of:

(a) Mandatory reporter responsibility to report suspected child abuse;

(b) Responsibility to immediately notify the child's parent or guardian, or any other person specified by the child's parent or guardian, of any injury, illness, accident, or unusual circumstance involving the child that occurs when the provider is providing individual services, training, or supervision that may have a serious effect on the health, safety, physical or emotional well-being, or level of services required;

(c) Limits of payment:

(A) Long-term support fund payments for the agreed-upon services are considered full payment and the provider under no circumstances may demand or receive additional payment for these services from the family or any other source.

(B) The provider must bill all third party resources before using long-term support funds.

(d) The provisions of section (6) of this rule regarding sanctions that may be imposed on providers;

(e) The requirement to maintain a drug-free workplace; and

(f) The payment process, including payroll or contractor payment schedules or timelines.

(4) The method and schedule of payment must be specified in written agreements between the CDDP and the child's parent or guardian.

(a) Support expenses must be separately projected, tracked, and expensed, including separate contracts, employment agreements, and timekeeping for staff working with more than one eligible child.

(b) The CDDP is specifically prohibited from reimbursement of families for expenses or advancing funds to families to obtain services. The CDDP must issue payment, or arrange through fiscal intermediary services to issue payment, directly to the qualified provider on behalf of the family after approved services described in the child's Annual Support Plan have been satisfactorily delivered.

(5) The CDDP must inform families in writing of records and procedures required in OAR 411-308-0030 regarding expenditure of long-term support funds. During development of the child's Annual Support Plan, the services coordinator must determine the need or preference for the CDDP to provide support with documentation and procedural requirements and must delineate responsibility for maintenance of records in written service agreements.

(6) SANCTIONS FOR INDEPENDENT PROVIDERS, PROVIDER ORGANIZATIONS, AND GENERAL BUSINESS PROVIDERS.

(a) A sanction may be imposed on a provider when the CDDP determines that, at some point after the provider's initial qualification and authorization to provide supports purchased with long-term support funds, the provider has:

(A) Been convicted of any crime that would have resulted in an unacceptable background check upon hiring or authorization of service;

(B) Been convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;

(C) Surrendered his or her professional license or certificate, or had his or her professional license or certificate suspended, revoked, or otherwise limited;

(D) Failed to safely and adequately provide the authorized long-term support services, or other similar services in a Department program;

(E) Had a founded report of child abuse or substantiated abuse;

(F) Failed to cooperate with any Department or CDDP investigation or grant access to or furnish, as requested, records or documentation;

(G) Billed excessive or fraudulent charges or been convicted of fraud;

(H) Made false statement concerning conviction of crime or substantiation of abuse;

(I) Falsified required documentation;

(J) Failed to comply with the provisions of section (4) of this rule and OAR 411-308-0130; or

(K) Been suspended or terminated as a provider by another Office within the Department.

(b) The following sanctions may be imposed on a provider:

(A) The provider may no longer be paid with long-term support funds; or

(B) The provider may not be allowed to provide services for a specified length of time or until specified conditions for reinstatement are met and approved by the CDDP or the Department, as applicable.

(c) If the CDDP makes a decision to sanction a provider, the CDDP must notify the provider by mail of the intent to sanction.

(d) The provider may appeal a sanction within 30 days of the date the sanction notice was mailed to the provider. The provider must appeal a sanction separately from any appeal of audit findings and overpayments.

(A) A provider may appeal a sanction by requesting an administrative review by the Director.

(B) For an appeal regarding provision of Medicaid services, written notice of the appeal must be received by the Department within 30 days of the date the sanction notice was mailed to the provider.

(e) A provider may be immediately suspended by the CDDP as a protective service action or in the case of alleged criminal activity that could pose a danger to the child. The suspension may continue until the issues are resolved.

(f) At the discretion of the Department, providers who have previously been terminated or suspended by any Office within the Department may not be authorized as providers of Medicaid services.

Stat. Auth.: ORS 409.050, 410.070

Stats. Implemented: ORS 427.005, 427.007, & 430.610 - 430.670

Hist.: SPD 7-2009(Temp), f. & cert. ef. 7-1-09 thru 12-28-09; SPD 20-2009, f. 12-23-09, cert. ef. 12-28-09; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 5-2010, f. 6-29-10, cert. ef. 7-1-10; SPD 21-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-308-0120

Supports Purchased with Long-Term Support Funds

(1) For an initial or annual support plan that is authorized on or after July 1, 2013, when conditions of purchase are met and provided purchases are not prohibited under OAR 411-308-0110, long-term support funds may be used to purchase a combination of the following supports based upon the needs of the child consistent with the child's Annual Support Plan and available funding:

(a) Community First Choice State Plan services:

(A) Specialized consultation including behavior consultation as described in section (3) of this rule;

(B) Community nursing services as described in section (4) of this rule;

(C) Environmental accessibility adaptations as described in section (5) of this rule;

(D) In-home daily care as described in section (6) of this rule;

(E) Respite as described in section (7) of this rule;

(F) Specialized equipment and supplies as described in section (8) of this rule;

(G) Chore services as described in section (9) of this rule; and

(H) Transportation as described in section (10) of this rule.

(b) As a waivered service, family training as described in section (11) of this rule.

(2) Family caregiver supports shall not be included in an Annual Support Plan authorized on or after July 1, 2013.

(3) SPECIALIZED CONSULTATION – BEHAVIOR CONSULTATION. Behavior consultation is the purchase of individualized consultation provided only as needed in the family home to respond to a specific problem or behavior identified by the child's parent or guardian and the services coordinator. Behavior consultation services must be documented in a Behavior Support Plan prior to final payment for the services.

(a) Behavior consultation is only authorized to support a primary caregiver in their caregiving role, not as a replacement for an educational service offered through the school.

(b) Behavior consultation must include:

(A) Working with the family to identify:

(i) Areas of a child's family home life that are of most concern for the family and child;

(ii) The formal or informal responses the family or provider has used in those areas; and

(iii) The unique characteristics of the family that may influence the responses that may work with the child.

(B) ASSESSING THE CHILD. The behavior consultant utilized by the family must conduct an assessment and interact with the child in the family home and community setting in which the child spends most of their time. The assessment must include:

(i) Specific identification of the behaviors or areas of concern;

(ii) Identification of the settings or events likely to be associated with or to trigger the behavior;

(iii) Identification of early warning signs of the behavior;

(iv) Identification of the probable reasons that are causing the behavior and the needs of the child that are being met by the behavior, including the possibility that the behavior is:

(I) An effort to communicate;

(II) The result of a medical condition;

(III) The result of an environmental cause; or

(IV) The symptom of an emotional or psychiatric disorder.

(v) Evaluation and identification of the impact of disabilities (i.e. autism, blindness, deafness, etc.) that impact the development of strategies and affect the child and the area of concern;

(vi) An assessment of current communication strategies; and

(vii) Identification of possible alternative or replacement behaviors.

(C) Developing a variety of positive strategies that assist the family and provider to help the child use acceptable, alternative actions to meet the child's needs in the most cost effective manner. These strategies may include changes in the physical and social environment, developing effective communication, and appropriate responses by a family and provider to the early warning signs.

(i) Positive, preventive interventions must be emphasized.

(ii) The least intrusive intervention possible must be used.

(iii) Abusive or demeaning interventions must never be used.

(iv) The strategies must be adapted to the specific disabilities of the child and the style or culture of the family.

(D) Developing emergency and crisis procedures to be used to keep the child, family, and provider safe. When interventions in the behavior of the child are necessary, positive, preventative, non-aversive interventions that conform to OIS must be utilized. The Department does not pay a provider to use protective physical intervention on a child receiving long-term support.

(E) Developing a written Behavior Support Plan consistent with OIS that includes the following:

(i) Use of clear, concrete language and in a manner that is understandable to the family and provider; and

(ii) Describes the assessment, recommendations, strategies, and procedures to be used.

(F) Teaching the provider and family the recommended strategies and procedures to be used in the child's natural environment.

(G) Monitoring, assessing, and revising the Behavior Support Plan as needed based on the effectiveness of implemented strategies. If protective physical intervention techniques are included in the Behavior Support Plan for use by the family, monthly practice of the technique must be observed by an OIS approved trainer.

(c) Behavior consultation does not include:

(A) Mental health therapy or counseling;

(B) Health or mental health plan coverage; or

(C) Educational services including but not limited to consultation and training for classroom staff, adaptations to meet the needs of the child at school, assessment in the school setting for the purposes of an Individualized Education Program, or any service identified by the school as required to carry out the child's Individualized Education Program.

(4) COMMUNITY NURSING SERVICES. Community nursing services as defined in OAR 411-308-0020 include:

(a) Evaluation and identification of supports that minimize health risks, while promoting the child's autonomy and self-management of healthcare;

(b) Medication reviews;

(c) Collateral contact with the services coordinator regarding the child's community health status to assist in monitoring safety and well-being and to address needed changes to the person-centered Annual Support Plan; and

(d) Delegation of nursing tasks to a provider and parent or guardian so that they may safely perform health related tasks.

(5) ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS. Environmental accessibility adaptations are physical adaptations to a family home that are necessary to ensure the health, welfare, and safety of the child in the family home due to the child's intellectual or developmental disability or that are necessary to enable the child to function with greater independence around the family home and in family activities.

(a) Environmental accessibility adaptations include but are not limited to:

(A) An environmental modification consultation to determine the appropriate type of adaptation to ensure the health, welfare, and safety of the child;

(B) Installation of shatter-proof windows;

(C) Hardening of walls or doors;

(D) Specialized, hardened, waterproof, or padded flooring;

(E) An alarm system for doors or windows;

(F) Protective covering for smoke detectors, light fixtures, and appliances;

(G) Sound and visual monitoring systems;

(H) Fencing;

(I) Installation of ramps, grab-bars, and electric door openers;

(J) Adaptation of kitchen cabinets and sinks;

(K) Widening of doorways;

(L) Handrails;

(M) Modification of bathroom facilities;

(N) Individual room air conditioners for a child whose temperature sensitivity issues create behaviors or medical conditions that put the child or others at risk;

(O) Installation of non-skid surfaces;

(P) Overhead track systems to assist with lifting or transferring;

(Q) Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the child;

(R) Modifications for the primary vehicle used by the child that are necessary to meet the unique needs of the child and ensure the health, welfare, and safety of the child (lift, belts, special safety harnesses, interior alterations such as seats, head, and leg rests, or other unique modifications to keep the child safe in the vehicle); and

(S) Adaptations to control lights, heat, stove, etc.

(b) Environmental accessibility adaptations exclude:

(A) Adaptations or improvements to the family home that are of general utility and are not for the direct safety, remedial, or long term benefit to the child;

(B) Adaptations that add to the total square footage of the family home; and

(C) General repair or maintenance and upkeep required for the family home or motor vehicle, including repair of damage caused by the child.

(c) Environmental modifications are limited to $5,000 per modification. A services coordinator may request approval for additional expenditures through the Department prior to expenditure. Approval is based on the child's service needs and goals and the Department's determination of appropriateness and cost-effectiveness.

(d) Environmental modifications must be tied to supporting activities of daily living, instrumental activities of daily living, and health-related tasks as identified in the Plan of Care.

(e) Modifications over $500 must be completed by a state licensed contractor. Any modification requiring a permit must be inspected and be certified as in compliance with local codes by local inspectors and filed in provider file prior to payment. Environmental modifications must be made within the existing square footage of the family home, except for external ramps, and cannot add to the square footage of the building. Payment to the contractor is to be withheld until the work meets specifications.

(f) The CDDP must obtain written authorization from the owner of a rental structure before any environmental accessibility adaptations are made to that structure. This does not preclude any reasonable accommodation required under the Americans with Disabilities Act.

(6) IN-HOME DAILY CARE. In-home daily care services include the purchase of direct provider support provided to the child in the family home or community by qualified individual providers and agencies. Provider assistance provided through in-home daily care must support the child to

live as independently as appropriate for the child's age and must be based on the identified needs of the child, supporting the family in their primary caregiving role. Primary caregivers are expected to be present or immediately available during the provision of in-home daily care.

(a) In-home daily care services provided by qualified providers or agencies include:

(A) Basic personal hygiene — Assistance with bathing and grooming;

(B) Toileting, bowel, and bladder care — Assistance in the bathroom, diapering, external cleansing of perineal area, and care of catheters;

(C) Mobility — Transfers, comfort, positioning, and assistance with range of motion exercises;

(D) Nutrition — feeding and monitoring intake and output;

(E) Skin care — Dressing changes;

(F) Physical healthcare including delegated nursing tasks;

(G) Supervision — Providing an environment that is safe and meaningful for the child and interacting with the child to prevent danger to the child and others, and maintain skills and behaviors required to live in the home and community;

(H) Assisting the child with appropriate leisure activities to enhance development in the family home and community, and provide training and support in personal environmental skills;

(I) Communication — Assisting the child in communicating, using any means used by the child;

(J) Neurological — Monitoring of seizures, administering medication, and observing status; and

(K) Accompanying the child and family to health related appointments.

(b) In-home daily care services must:

(A) Be previously authorized by the CDDP before services begin;

(B) Be delivered through the most cost effective method as determined by the services coordinator; and

(C) Only be provided when the child is present to receive services.

(c) In-home daily care services exclude:

(A) Hours that supplant the natural supports and services available from family, community, other government or public services, insurance plans, schools, philanthropic organizations, friends, or relatives;

(B) Hours to allow a primary caregiver to work or attend school;

(C) Support generally provided at the child's age by parents or other family members;

(D) Educational and supportive services provided by schools as part of a free and appropriate education for children and young adults under the Individuals with Disabilities Education Act;

(E) Services provided by the family; and

(F) Home schooling.

(d) In-home daily care services may not be provided on a 24-hour shift-staffing basis. The child's primary caregiver is expected to provide at least 40 hours of care each week and supervise the child each day with the exception of overnight respite. The 40 hours of care and supervision may not include hours when the child's primary caregiver is sleeping.

(7) RESPITE. Respite services are provided to a child on a periodic or intermittent basis furnished because of the temporary absence of, or need for relief of, the primary caregiver.

(a) Respite may include both day and overnight services that may be provided in:

(A) The family home;

(B) A licensed, certified, or otherwise regulated setting;

(C) A qualified provider's home. If overnight respite is provided in a qualified provider's home, the CDDP and the child's parent or guardian must document that the home is a safe setting for the child; or

(D) A disability-related or therapeutic recreational camp.

(b) The CDDP does not authorize respite services:

(A) To allow primary caregivers to attend school or work;

(B) That are ongoing and occur on more than a periodic schedule, such as eight hours a day, five days a week;

(C) On more than 14 consecutive overnight stays in a calendar month;

(D) For more than 10 days per individual plan year when provided at a specialized camp;

(E) For vacation travel and lodging expenses; or

(F) To pay for room and board if provided at a licensed site or specialized camp.

(8) SPECIALIZED EQUIPMENT AND SUPPLIES. Specialized equipment and supplies include the purchase of devices, aids, controls, supplies, or appliances that are necessary to enable a child to increase the child's abilities to perform and support activities of daily living, or to perceive, control, or communicate with the environment in which the child lives.

(a) Electronic devices to secure assistance in an emergency in the community and other reminders such as medication minders and alert systems for ADL/IADL supports, or mobile electronic devices. Expenditures for electronic devices of more than $500 in a plan year require Department approval.

(b) Assistive technology to provide additional security and replace the need for direct interventions to allow self direction of care and maximize independence. Examples include motion sound sensors, two-way communication systems, automatic faucets and soap dispensers, incontinent and fall sensors, or other electronic backup systems.

(A) Limit of $5000 per year without Department approval.

(B) Any single device or assistance costing more than $500 must be approved by the Department.

(c) Assistive devices. Examples include durable medical equipment, mechanical apparatus, electrical appliance or information technology device to assist and enhance an individual's independence in performing ADL/IADLs, not covered by other Medicaid programs. Limit of $5000 per year without Department approval. Any single device or assistance costing more than $500 must be approved by the department.

(d) The purchase of specialized equipment and supplies may include the cost of a professional consultation, if required, to assess, identify, adapt, or fit specialized equipment. The cost of professional consultation may be included in the purchase price of the equipment.

(e) To be authorized by the CDDP, specialized equipment and supplies must be:

(A) In addition to any medical equipment and supplies furnished under OHP and private insurance;

(B) Determined necessary to the daily functions of the child; and

(C) Directly related to the child's disability.

(f) Specialized equipment and supplies exclude:

(A) Items that are not necessary or of direct medical or remedial benefit to the child;

(B) Specialized equipment and supplies intended to supplant similar items furnished under OHP or private insurance;

(C) Items available through family, community, or other governmental resources;

(D) Items that are considered unsafe for the child;

(E) Toys or outdoor play equipment; and

(F) Equipment and furnishings of general household use.

(g) Funding for specialized equipment with an expected life of more than one year is one time funding that is not continued in subsequent plan years. Specialized equipment may only be included in a child's Annual Support Plan when all other public and private resources for the equipment have been exhausted.

(h) The CDDP must secure use of equipment or furnishings costing more than $500 through a written agreement between the CDDP and the child's parent or guardian that specifies the time period the item is to be available to the child and the responsibilities of all parties should the item be lost, damaged, or sold within that time period. Any equipment or supplies purchased with long-term support funds that are not used according to the child's Annual Support Plan, or according to the written agreement between the Department and the child's parent or guardian, may be immediately recovered.

(9) CHORE SERVICES. Chore services may be provided only in situations where no one else in the household is capable of either performing or paying for the services and no other relative, caregiver, landlord, community, volunteer agency, or third-party payer is capable of or responsible for providing these services

(10)TRANSPORTATION. Non-medical transportation is provided in order to enable a child to gain access to community services, activities, and resources as specified in the child's Annual Support Plan. Non-medical transportation excludes:

(a) Transportation provided by family members;

(b) Transportation used for behavioral intervention or calming;

(c) Transportation normally provided by schools and by the primary caregiver for children of similar age without disabilities;

(d) Purchase of any family vehicle;

(e) Vehicle maintenance and repair;

(f) Reimbursement for out-of-state travel expenses;

(g) Ambulance services; or

(h) Transportation services that may be obtained through other means such as OHP or other public or private resources available to the child.

(11) FAMILY TRAINING. Family training services include the purchase of training, coaching, counseling, and support that increase the family's ability to care for and maintain the child in the family home.

(a) Family training services include:

(A) Counseling services that assist the family with the stresses of having a child with an intellectual or developmental disability.

(i) To be authorized, the counseling services must:

(I) Be provided by licensed providers including but not limited to psychologists licensed under ORS 675.030, professionals licensed to practice medicine under 677.100, social workers licensed under 675.530, and counselors licensed under 675.715;

(II) Directly relate to the child's intellectual or developmental disability and the ability of the family to care for the child; and

(III) Be short-term.

(ii) Counseling services are excluded for:

(I) Therapy that may be obtained through OHP or other payment mechanisms;

(II) General marriage counseling;

(III) Therapy to address family members' psychopathology;

(IV) Counseling that addresses stressors not directly attributed to the child;

(V) Legal consultation;

(VI) Vocational training for family members; and

(VII) Training for families to carry out educational activities in lieu of school.

(B) Registration fees for organized conferences, workshops, and group trainings that offer information, education, training, and materials about the child's intellectual or developmental disability, medical, or health conditions.

(i) Conferences, workshops, or group trainings must be prior authorized by the services coordinator and include those that:

(I) Directly relate to the child's intellectual or developmental disability; and

(II) Increase the knowledge and skills of the family to care for and maintain the child in the family home.

(ii) Conference, workshop, or group trainings costs exclude:

(I) Registration fees in excess of $500 per family for an individual event;

(II) Travel, food, and lodging expenses;

(III) Services otherwise provided under OHP or available through other resources; or

(IV) Costs for individual family members who are employed to care for the child.

(b) Funding for family training is one time funding that is not continued in subsequent plan years. Funding for each family training event must be specifically approved through a regional process to ensure the family training event is necessary to prevent out-of-home placement or to return the child to the family home, and to ensure the family training event is cost effective. Family training may only be included in a child's Annual Support Plan when all other public and private resources for the event have been exhausted.

Stat. Auth.: ORS 409.050, 410.070

Stats. Implemented: ORS 427.005, 427.007, & 430.610 - 430.670

Hist.: SPD 7-2009(Temp), f. & cert. ef. 7-1-09 thru 12-28-09; SPD 20-2009, f. 12-23-09, cert. ef. 12-28-09; SPD 4-2011(Temp), f. & cert. ef. 2-1-11 thru 7-31-11; SPD 20-2011, f. & cert. ef. 8-1-11; SPD 21-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

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Rules Amended: 411-320-0020, 411-320-0030, 411-320-0040, 411-320-0060, 411-320-0070, 411-320-0090, 411-320-0100, 411-320-0110, 411-320-0120, 411-320-0130
Subject: The Department of Human Services (Department) is immediately amending the rules for community developmental disability programs (CDDPs) in OAR chapter 411, division 320 to:

Reflect new definitions applicable to Community First Choice State Plan services;

Provide choice counseling to reflect the individual's right to choice for provider types and services as is required by the Code of Federal Regulations for waivered and state plan services;

Describe and coincide with the services available in the Community First Choice State Plan and Home and Community-Based Waiver amendments;

Require a functional needs assessment as part of an individual's service planning process;

Clarify the service coordinator's and personal agent's responsibilities for Individual Support Plans to bring the Department into compliance with Code of Federal Regulations for waivered and state plan services; and

Reflect new or revised responsibilities of the CDDPs, support services brokerages, and the Department as a result of Community First Choice State Plan services and Home and Community-Based Waiver amendments.
Rules Coordinator: Christina Hartman—(503) 945-6398

411-320-0020
Definitions

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 320:

(1) "24-Hour Residential Program" means a comprehensive residential home or facility licensed by the Department under ORS 443.410 to provide residential care and training to individuals with intellectual or developmental disabilities.

(2) "Abuse" means:

(a) Abuse of a child:

(A) As defined in ORS 419B.005; and

(B) Abuse as defined in OAR 407-045-0260, when a child resides in:

(i) Homes or facilities licensed to provide 24-hour residential services for children with intellectual or developmental disabilities; or

(ii) Agencies licensed or certified by the Department to provide proctor foster care for children with intellectual or developmental disabilities.

(b) Abuse of an adult as defined in OAR 407-045-0260.

(3) "Abuse Investigation and Protective Services" means reporting and investigation activities as required by OAR 407-045-0300 and any subsequent services or supports necessary to prevent further abuse as required by OAR 407-045-0310.

(4) "Accident" means an event that results in injury or has the potential for injury even if the injury does not appear until after the event.

(5) "Adaptive Behavior" means the degree to which an individual meets the standards of personal independence and social responsibility expected for age and culture group. Other terms used to describe adaptive behavior include but are not limited to adaptive impairment, ability to function, daily living skills, and adaptive functioning. Adaptive behaviors are everyday living skills including but not limited to walking (mobility), talking (communication), getting dressed or toileting (self-care), going to school or work (community use), and making choices (self-direction).

(a) Adaptive behavior is measured by a standardized test administered by a psychologist, social worker, or other professional with a graduate degree and specific training and experience in individual assessment, administration, and test interpretation of adaptive behavior scales for individuals with intellectual or developmental disabilities.

(b) "Significant impairment" in adaptive behavior means a composite score of at least two standard deviations below the norm or two or more areas of functioning that are at least two standard deviations below the norm including but not limited to communication, mobility, self-care, socialization, self-direction, functional academics, or self-sufficiency as indicated on a standardized adaptive test.

(6) "Administrative Review" means the formal process that is used by the Department when an individual or an individual's representative is not satisfied with the decision made by the community developmental disability program or support services brokerage about a complaint involving the provision of services or a service provider.

(7) "Adult" means an individual 18 years or older with an intellectual or developmental disability.

(8) "Advocate" means a person other than paid staff who has been selected by an individual, or by the individual's legal representative, to help the individual understand and make choices in matters relating to identification of needs and choices of services, especially when rights are at risk or have been violated.

(9) "Annual Plan" means a written summary the services coordinator completes for an individual 18 years or older who is not receiving support services or comprehensive services. (10) "Care" means supportive services including but not limited to provision of room and board, supervision, protection, and assistance in bathing, dressing, grooming, eating, management

of money, transportation, or recreation. The term "care" is synonymous with "services".

(11) "Case Management" means an organized service to assist individuals to select, obtain, and utilize resources and services.

(12) "CDDP" means "Community Developmental Disability Program".

(13) "Chemical Restraint" means the use of a psychotropic drug or other drugs for punishment, or to modify behavior, in place of a meaningful behavior or treatment plan.

(14) "Child" means an individual who is less than 18 years of age that has a provisional determination of an intellectual or developmental disability.

(15) "Choice" means an individual's expression of preference, opportunity for, and active role in decision-making related to the services received and from whom, including but not limited to case management, service providers, and service settings. Personal outcomes, goals, and activities are supported in the context of balancing an individual's rights, risks, and personal choices. Individuals are supported in opportunities to make changes when so expressed. Choice may be communicated verbally, through sign language, or by other communication methods.

(16) "Choice Counseling" means the sharing of information about case management and other service delivery options available to individuals with intellectual or developmental disabilities.

(17) "Choice Advisor" means an objective third party who meets the qualifications identified in OAR 411-320-0030(4)(c), who provides information in an impartial manner about the choices an eligible individual has regarding the provision of their case management services.

(18) "Community Developmental Disability Program (CDDP)" means the entity that is responsible for planning and delivery of services for individuals with intellectual or developmental disabilities in a specific geographic service area of the state operated by or under a contract with the Department or a local mental health authority.

(19) "Community First Choice State Plan" means Oregon's state plan amendment authorized under section 1915(k) of the Social Security Act.

(20) "Community Mental Health and Developmental Disability Program (CMHDDP)" means an entity that operates or contracts for all services for individuals with mental or emotional disturbances, drug abuse problems, intellectual or developmental disabilities, and alcoholism and alcohol abuse problems under the county financial assistance contract with the Department or Oregon Health Authority.

(21) "Complaint" means a verbal or written expression of dissatisfaction with services or service providers.

(22) "Complaint Investigation" means an investigation of any complaint that has been made to a proper authority that is not covered by an abuse investigation.

(23) "Comprehensive Services" mean developmental disability services and supports that include 24 hour residential services provided in a group home, foster home, or through a supported living program. Comprehensive services are regulated by the Department alone or in combination with an associated Department-regulated employment or community inclusion program. Comprehensive services are in-home services provided to an individual with an intellectual or developmental disability when the individual receives case management services from a community developmental disability program. Comprehensive services do not include support services for adults with intellectual or developmental disabilities enrolled in brokerages.

(24) "County of Origin" means the individual's county of residence, unless a minor, then county of origin means the county where the jurisdiction of the child's guardianship exists.

(25) "Crisis" means:

(a) A situation as determined by a qualified services coordinator that would result in civil court commitment under ORS 427.215 to 427.306 and for which no appropriate alternative resources are available; or

(b) Risk factors described in OAR 411-320-0160(2) are present for which no appropriate alternative resources are available.

(26) "Crisis Diversion Services" mean short-term services provided for up to 90 days, or on a one-time basis, directly related to resolving a crisis, and provided to, or on behalf of, an individual eligible to receive crisis services.

(27) "Crisis Plan" means the community developmental disability program or regional crisis diversion program generated document, serving as the justification for, and the authorization of crisis supports and expenditures pertaining to an individual receiving crisis services provided under these rules.

(28) "Current Documentation" means documentation relating to an individual's intellectual or developmental disability in regards to the individual's functioning within the last three years. Current documentation may include but is not limited to annual plans, behavior support plans, educational records, medical assessments related to the intellectual or developmental disability, psychological evaluations, and assessments of adaptive behavior.

(29) "Department" means the Department of Human Services (DHS). The term "Department" is synonymous with "Division (SPD)".

(30) "Developmental Disability (DD)" means a neurological condition that:

(a) Originates before the individual reaches the age of 22 years, except that in the case of intellectual disability, the condition is manifested before the age of 18;

(b) Originates in and directly affects the brain and has continued, or is expected to continue, indefinitely;

(c) Constitutes a significant impairment in adaptive behavior as diagnosed and measured by a qualified professional; and

(d) Is not primarily attributed to other conditions, including but not limited to mental or emotional disorder, sensory impairment, substance abuse, personality disorder, learning disability, or Attention Deficit Hyperactivity Disorder (ADHD).

(31) "DHS Quality Management Strategy" means the Department's Quality Assurance Plan that includes the quality assurance strategies for the Department (http://www.oregon.gov/DHS/spd/qa/app_h_qa.pdf).

(32) "Director" means the Director of the Department's Office of Developmental Disability Services, or the Director's designee. The term "Director" is synonymous with "Assistant Director".

(33) "Eligibility Determination" means a decision by a community developmental disability program or by the Department regarding a person's eligibility for developmental disability services pursuant to OAR 411-320-0080 and is either a decision that a person is eligible or ineligible for developmental disability services.

(34) "Eligibility Specialist" means an employee of the community developmental disability program or other agency that contracts with the county or Department to determine developmental disability eligibility.

(35) "Entry" means admission to a Department-funded developmental disability service.

(36) "Exit" means termination or discontinuance of:

(a) Services from a service provider; or

(b) Department-funded developmental disability services.

(37) "Family Member" means husband or wife, domestic partner, natural parent, child, sibling, adopted child, adoptive parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, aunt, uncle, niece, nephew, or first cousin.

(38) "Founded Reports" means the Department's Children, Adults, and Families Division or Law Enforcement Authority (LEA) determination, based on the evidence, that there is reasonable cause to believe that conduct in violation of the child abuse statutes or rules has occurred and such conduct is attributable to the person alleged to have engaged in the conduct.

(39) "Functional Needs Assessment (FNAT)" means an assessment that documents the level of need, accommodates an individual's participation in service planning, and includes:

(a) Completing a comprehensive and holistic assessment;

(b) Surveying physical, mental, and social functioning; and

(c) Identifying risk factors, choices and preferences, and service needs.

(40) "Guardian" means the parent of a child, or the person or agency appointed and authorized by a court to make decisions about services for a child.

(41) "Health Care Provider" means the person or health care facility licensed, certified, or otherwise authorized or permitted by Oregon law to administer health care in the ordinary course of business or practice of a profession.

(42) "Health Care Representative" means:

(a) A health care representative as defined in ORS 127.505; or

(b) A person who has authority to make health care decisions for an individual under the provisions of OAR chapter 411, division 365.

(43) "Hearing" means the formal process following an action that would terminate, suspend, reduce, or deny a service. This is a formal process required by federal law (42 CFR 431.200-250). A hearing is also known as a Medicaid Fair Hearing, Contested Case Hearing, and Administrative Hearing.

(44) "Home" means an individual's primary residence that is not under contract with the Department to provide services to an individual as a licensed or certified foster home, residential care facility, assisted living facility, nursing facility, or other residential support program site.

(45) "Home and Community-Based Waivered Services" mean the services approved by the Centers for Medicare and Medicaid Services in accordance with Section 1915(c) and 1115 of the Social Security Act.

(46) "Imminent Risk" means:

(a) An adult who is in crisis and shall be civilly court-committed to the Department under ORS 427.215 to 427.306 within 60 days without the use of crisis diversion services; or

(b) A child who is in crisis and shall require out-of-home placement within 60 days without the use of crisis diversion services.

(47) "Incident Report" means the written report of any unusual incident involving an individual.

(48) "Independence" means the extent to which individuals exert control and choice over their own lives.

(49) "Individual" means an adult or a child with an intellectual or developmental disability applying for or determined eligible for developmental disability services.

(50) "Individualized Education Plan (IEP)" means the written plan of instructional goals and objectives developed in conference with an individual and the individual's legal representative, teacher, and a representative of the school district.

(51) "Individual Support Plan (ISP)" means the written details of the supports, activities, and resources required for an individual to achieve personal outcomes. Individual support needs are identified through a functional needs assessment. The manner in which services are delivered, service providers, and the frequency of services are reflected in an ISP. The ISP is developed at minimum annually to reflect decisions and agreements made during a person-centered process of planning and information gathering. The ISP includes an individual's Plan of Care for Medicaid purposes and reflects whether services are purchased through a waiver, state plan, or provided through an individual's natural supports.

(52) "Individual Support Plan (ISP) Team" means a team composed of an individual receiving services and the individual's legal representative, services coordinator or personal agent, and others chosen by the individual. Others chosen by the individual may include service providers, family members, or other persons requested by the individual.

(53) "Informal Adaptive Behavior Assessment" means:

(a) Observations of the adaptive behavior impairments recorded in the individual's progress notes by a services coordinator or a trained eligibility specialist, with at least two years experience working with individuals with intellectual or developmental disabilities.

(b) A standardized measurement of adaptive behavior such as a Vineland Adaptive Behavior Scale or Adaptive Behavior Assessment System that is administered and scored by a social worker, or other professional with a graduate degree and specific training and experience in individual assessment, administration, and test interpretation of adaptive behavior scales for individuals.

(54) "Integration" as defined in ORS 427.005 means:

(a) The use by individuals with intellectual or developmental disabilities of the same community resources used by and available to other persons;

(b) Participation by individuals with intellectual or developmental disabilities in the same community activities in which persons without an intellectual or developmental disability participate, together with regular contact with persons without an intellectual or developmental disability; and

(c) Individuals with intellectual or developmental disabilities reside in homes or home-like settings that are in proximity to community resources and foster contact with persons in the community.

(55) "Intellectual Disability" means significantly sub-average general intellectual functioning defined as intelligence quotient's (IQ's) under 70 as measured by a qualified professional and existing concurrently with significant impairment in adaptive behavior that are manifested during the developmental period, prior to 18 years of age. Individuals of borderline intelligence, IQ's 70-75, may be considered to have intellectual disability if there is also significant impairment of adaptive behavior as diagnosed and measured by a qualified professional.

(56) "Intellectual Functioning" means functioning as assessed by a qualified professional using one or more individually administered general intelligence tests. For purposes of making eligibility determinations, intelligence tests do not include brief intelligence measurements.

(57) "ISP" means "Individual Support Plan" as defined in this rule.

(58) "Legal Representative" means:

(a) For a child, the parent unless a court appoints another person or agency to act as guardian; and

(b) For an adult, an attorney at law who has been retained by or for an individual or a person or agency authorized by a court to make decisions about services for an individual.

(59) "Level of Care" means an assessment completed by a services coordinator has determined an individual meets institutional level of care. An individual meets institutional level of care for an intermediate care facility for individuals with intellectual or developmental disabilities if:

(a) The individual has a condition of an intellectual disability or a developmental disability as defined in this rule and meets the eligibility criteria for developmental disability services as described in OAR 411-320-0080; and

(b) The individual has a significant impairment in one or more areas of adaptive functioning. Areas of adaptive functioning include self direction, self care, home living, community use, social, communication, mobility, or health and safety.

(60) "Local Mental Health Authority (LMHA)" means:

(a) The county court or board of county commissioners of one or more counties that operate a community mental health and developmental disability program;

(b) The tribal council in the case of a Native American reservation;

(c) The board of directors of a public or private corporation if the county declines to operate or contract for all or part of a community mental health and developmental disability program; or

(d) The advisory committee for the community developmental disability program covering a geographic service area when managed by the Department.

(61) "Management Entity" means the community developmental disability program or private corporation that operates the regional crisis diversion program, including acting as the fiscal agent for regional crisis diversion funds and resources.

(62) "Mandatory Reporter" means any public or private official as defined in OAR 407-045-0260 who:

(a) Comes in contact with and has reasonable cause to believe a child with or without an intellectual or developmental disability has suffered abuse, or comes in contact with any person whom the official has reasonable cause to believe abused a child with or without an intellectual or developmental disability, regardless of whether or not the knowledge of the abuse was gained in the reporter's official capacity. Nothing contained in ORS 40.225 to 40.295 affects the duty to report imposed by this section, except that a psychiatrist, psychologist, clergy, attorney, or guardian ad litem appointed under ORS 419B.231 is not required to report if the communication is privileged under ORS 40.225 to 40.295.

(b) While acting in an official capacity, comes in contact with and has reasonable cause to believe an adult with an intellectual or developmental disability has suffered abuse, or comes in contact with any person whom the official has reasonable cause to believe abused an adult with intellectual or developmental disabilities. Pursuant to ORS 430.765(2) psychiatrists, psychologists, clergy, and attorneys are not mandatory reporters with regard to information received through communications that are privileged under ORS 40.225 to 40.295.

(63) "Mechanical Restraint" means any mechanical device, material, object, or equipment that is attached or adjacent to an individual's body that the individual cannot easily remove or easily negotiate around that restricts freedom of movement or access to the individual's body.

(64) "Medication" means any drug, chemical, compound, suspension, or preparation in suitable form for use as a curative or remedial substance taken either internally or externally by any person.

(65) "Mental Retardation" is synonymous with "intellectual disability".

(66) "Monitoring" means the periodic review of the implementation of services identified in the Individual Support Plan or annual summary, and the quality of services delivered by other organizations.

(67) "Natural Supports" or "Natural Support System" means the resources available to an individual from the individual's relatives, friends, significant others, neighbors, roommates, and the community. Services provided by natural supports are resources that are not paid for by the Department.

(68) "Nurse" means a person who holds a current license from the Oregon Board of Nursing as a registered nurse or licensed practical nurse pursuant to ORS chapter 678.

(69) "OAPPI" means the Department's Office of Adult Abuse Prevention and Investigation.

(70) "Oregon Intervention System (OIS)" means the system of providing training to people who work with designated individuals to provide elements of positive behavior support and non-aversive behavior intervention. OIS uses principles of pro-active support and describes approved physical intervention techniques that are used to maintain health and safety.

(71) "OSIP-M" means Oregon Supplemental Income Program-Medical as defined in OAR 461-101-0010. OSIP-M is Oregon Medicaid insurance coverage for an individual who meets eligibility criteria as described in OAR chapter 461.

(72) "Personal Agent" means a person who is a case manager for the provision of case management services, works directly with individuals and the individuals' families to provide or arrange for support services as described in OAR chapter 411, division 340, meets the qualifications set forth in OAR 411-340-0150, and is:

(a) A trained employee of a brokerage; or

(b) A person who has been engaged under contract to the brokerage to allow the brokerage to meet responsibilities in geographic areas where personal agent resources are severely limited.

(73) "Person-Centered Planning" means:

(a) A process, either formal or informal, for gathering and organizing information that helps an individual:

(A) Determine and describe choices about personal goals, activities, and lifestyle preferences;

(B) Design strategies and networks of support to achieve goals and a preferred lifestyle using individual strengths, relationships, and resources; and

(C) Identify, use, and strengthen naturally occurring opportunities for support at home and in the community.

(b) The methods for gathering information vary, but all are consistent with individual needs and preferences.

(74) "Physician" means a person licensed under ORS chapter 677 to practice medicine and surgery.

(75) "Physician Assistant" means a person licensed under ORS 677.505 to 677.525.

(76) "Plan of Care" means the Medicaid authorized written document within the context of an Individual Support Plan that is developed using person-centered planning that describes the supports, services, and resources provided or accessed to address the needs of an individual.

(77) "Productivity" means:

(a) Engagement in income-producing work by an individual that is measured through improvements in income level, employment status, or job advancement; or

(b) Engagement by an individual in work contributing to a household or community.

(78) "Protection" and "Protective Services" means necessary actions taken as soon as possible to prevent subsequent abuse or exploitation of the individual, to prevent self-destructive acts, and to safeguard an individual's person, property, and funds.

(79) "Protective Physical Intervention (PPI)" means any manual physical holding of, or contact with, an individual that restricts the individual's freedom of movement. The term "Protective Physical Intervention" is synonymous with "Physical Restraint".

(80) "Psychologist" means:

(a) A person possessing a doctorate degree in psychology from an accredited program with course work in human growth and development, tests, and measurement; or

(b) A state certified school psychologist.

(81) "Psychotropic Medication" means medication the prescribed intent of which is to affect or alter thought processes, mood, or behavior including but not limited to anti-psychotic, antidepressant, anxiolytic (anti-anxiety), and behavior medications. The classification of a medication depends upon its stated, intended effect when prescribed.

(82) "Qualified Professional" means a:

(a) Licensed clinical psychologist (Ph.D., Psy.D.) or school psychologist;

(b) Medical doctor (MD);

(c) Doctor of osteopathy (DO); or

(d) Nurse Practitioner.

(83) "Region" means a group of Oregon counties defined by the Department that have a designated management entity to coordinate regional crisis and backup services and be the recipient and administration of funds for those services.

(84) "Regional Crisis Diversion Program" means the regional coordination of the management of crisis diversion services for a group of designated counties that is responsible for the management of the following developmental disability services:

(a) Crisis intervention services;

(b) Evaluation of requests for new or enhanced services for certain groups of individuals eligible for developmental disability services; and

(c) Other developmental disability services that the counties compromising the region agree shall be delivered more effectively or automatically on a regional basis.

(85) "Respite" means intermittent services provided on a periodic but not more than 14 consecutive days, for the relief of, or due to the temporary absence of, a person normally providing supports to an individual unable to care for him or herself.

(86) "Restraint" means any physical hold, device, or chemical substance that restricts, or is meant to restrict, the movement or normal functioning of an individual.

(87) "Review" means a request for reconsideration of a decision made by a service provider, community developmental disability program, support services brokerage, or the Department.

(88) "School Aged" means the age at which a child is old enough to attend kindergarten through high school.

(89) "Service Element" means a funding stream to fund programs or services including but not limited to foster care, 24-hour residential, case management, supported living, support services, crisis diversion services, in-home comprehensive services, or family support.

(90) "Service Provider" means a public or private community agency or organization that provides recognized developmental disability services and is approved by the Department, or other appropriate agency, to provide these services. The term "provider" or "program" is synonymous with "service provider."

(91) "Services Coordinator" means an employee of the community developmental disability program or other agency that contracts with the county or Department, who is selected to plan, procure, coordinate, monitor Individual Support Plan services, and to act as a proponent for individuals.

(92) "State Training Center" means the Eastern Oregon Training Center.

(93) "Substantiated" means an abuse investigation has been completed by the Department or the Department's designee and the preponderance of the evidence establishes the abuse occurred.

(94) "Support" means the assistance that an individual requires, solely because of the affects of an intellectual or developmental disability, to maintain or increase independence, achieve community presence and participation, and improve productivity. Support is subject to change with time and circumstances.

(95) "Support Services Brokerage" means an entity, or distinct operating unit within an existing entity, that uses the principles of self-determination to perform the functions associated with planning and implementation of support services for individuals with intellectual or developmental disabilities.

(96) "These Rules" mean the rules in OAR chapter 411, division 320.

(97) "Transfer" means movement of an individual from a service site to another service site, administered or operated by the same service provider that has not been addressed within the individual's Individual Support Plan.

(98) "Transition Plan" means the written plan of services and supports for the period of time between an individual's entry into a particular service and the development of the individual's Individual Support Plan (ISP). The transition plan is approved by the individual's services coordinator and includes a summary of the services necessary to facilitate adjustment to the services offered, the supports necessary to ensure health and safety, and the assessments and consultations necessary for the ISP development.

(99) "Unusual Incident" means any incident involving an individual that includes serious illness or accidents, death, injury or illness requiring inpatient or emergency hospitalization, suicide attempts, a fire requiring the services of a fire department, an act of physical aggression, or any incident requiring abuse investigation.

(100) "Variance" means the temporary exception from a regulation or provision of these rules that may be granted by the Department, upon written application by the community developmental disability program.

(101) "Volunteer" means any person assisting a service provider without pay to support the services and supports provided to an individual.

Stat. Auth.: ORS 409.050, 410.070, 430.640

Stats. Implemented: ORS 427.005, 427.007, 430.610 - 430.695

Hist.: SPD 24-2003, f. 12-29-03, cert. ef. 1-1-04; SPD 28-2004, f. & cert. ef. 8-3-04; SPD 16-2005(Temp), f. & cert. ef. 11-23-05 thru 5-22-06; SPD 5-2006, f. 1-25-06, cert. ef. 2-1-06; SPD 9-2009, f. & cert. ef. 7-13-09; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 5-2010, f. 6-29-10, cert. ef. 7-1-10; SPD 6-2010(Temp), f. 6-29-10, cert. ef. 7-

4-10 thru 12-31-10; SPD 28-2010, f. 12-29-10, cert. ef. 1-1-11; SPD 31-2011, f. 12-30-11, cert. ef. 1-1-12; SPD 22-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-320-0030
Organization and Program Management

(1) ORGANIZATION AND INTERNAL MANAGEMENT. Each service provider of community developmental disability services funded by the Department must have written standards governing the operation and management of the program. Such standards must be up to date, available upon request, and include:

(a) An up-to-date organization chart showing lines of authority and responsibility from the LMHA to the CDDP manager and the components and staff within the agency;

(b) Position descriptions for all staff providing community developmental disability services;

(c) Personnel policies and procedures concerning:

(A) Recruitment and termination of employees;

(B) Employee compensation and benefits;

(C) Employee performance appraisals, promotions, and merit pay;

(D) Staff development and training;

(E) Employee conduct (including the requirement that abuse of an individual by an employee, staff, or volunteer of the CDDP is prohibited and is not condoned or tolerated); and

(F) Reporting of abuse (including the requirement that any employee of the CDDP is to report incidents of abuse when the employee comes in contact with and has reasonable cause to believe that an individual has suffered abuse). Notification of mandatory reporting status must be made at least annually to all employees and documented on forms provided by the Department.

(2) MANAGEMENT PLAN. The CDDP must maintain a current management plan assigning responsibility for the developmental disability services program management functions and duties described in this rule. The management plan must --

(a) Consider the unique organizational structure, policies, and procedures of the CDDP;

(b) Assure that the functions and duties are assigned to people who have the knowledge and experience necessary to perform them, as well as ensuring that the functions are implemented; and

(c) Reflect implementation of minimum quality assurance activities described in OAR 411-320-0045 that support the Department's Quality Management Strategy for meeting Centers for Medicare and Medicaid Services' waiver quality assurances, as required by 42 CFR 441.301 and 441.302.

(3) PROGRAM MANAGEMENT. Staff delivering developmental disability services must be organized under the leadership of a designated CDDP manager and receive clerical support services sufficient to perform their required duties.

(a) The LMHA, public entity, or the public or private corporation operating the CDDP must designate a full-time employee who must, on at least a part-time basis, be responsible for management of developmental disability services within a specific geographic service area.

(b) In addition to other duties as may be assigned in the area of developmental disability services, the CDDP must at a minimum develop and assure:

(A) Implementation of plans as may be needed to provide a coordinated and efficient use of resources available to serve individuals;

(B) Maintenance of positive and cooperative working relationships with families, advocates, service providers, support service brokerages, the Department, local government, and other state and local agencies with an interest in developmental disability services;

(C) Implementation of programs funded by the Department to encourage pursuit of defined program outcomes and monitor the programs to assure service delivery that is in compliance with related contracts and applicable local, state, and federal requirements;

(D) Collection and timely reporting of information as may be needed to conduct business with the Department including but not limited to licensing foster homes, collecting federal funds supporting services, and investigating complaints related to services or suspected abuse; and

(E) Use of procedures that attempt to resolve complaints involving individuals or organizations that are associated with developmental disability services.

(4) QUALIFIED STAFF. Each CDDP must provide a qualified CDDP manager, services coordinator, eligibility specialist, and abuse investigator specialist for adults with intellectual or developmental disabilities, or have an agreement with another CDDP to provide a qualified eligibility specialist and abuse investigator specialist for adults with intellectual or developmental disabilities.

(a) CDDP MANAGER.

(A) A CDDP manager must have knowledge of the public service system for developmental disability services in Oregon and at least:

(i) A bachelor's degree in behavioral science, social science, health science, special education, public administration, or human service administration and a minimum of four years experience with at least two of those years of experience in developmental disability services that provided recent experience in program management, fiscal management, and staff supervision; or

(ii) Six years of experience with staff supervision; or

(iii) Six years of experience in technical or professional level staff work related to developmental disability services.

(B) On an exceptional basis, the CDDP may hire a person who does not meet the qualifications in subsection (A) of this section if the county and the Department have mutually agreed on a training and technical assistance plan that assures that the person quickly acquires all needed skills and experience.

(C) When the position of CDDP manager becomes vacant, an interim CDDP manager must be appointed to serve until a permanent CDDP manager is appointed. The CDDP must request a variance as described in section (7) of this rule if the person appointed as interim CDDP manager does not meet the qualifications in subsection (A) of this section and the term of the appointment totals more than 180 days.

(b) CDDP SUPERVISOR. A CDDP supervisor (when available) must have knowledge of the public service system for developmental disability services in Oregon and at least:

(A) A bachelor's degree or equivalent course work in a field related to management such as business or public administration, or a field related to developmental disability services, may be substituted for up to three years required experience; or

(B) Five years of experience in staff supervision or five years of experience in technical or professional level staff work related to developmental disability services.

(c) SERVICES COORDINATOR. The services coordinator must have knowledge of the public service system for developmental disability services in Oregon and at least:

(A) A bachelor's degree in behavioral science, social science, or a closely related field; or

(B) A bachelor's degree in any field and one year of human services related experience (i.e., work providing assistance to individuals and groups with issue such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, housing); or

(C) An associate's degree in behavioral science, social science, or a closely related field and two years of human services related experience (i.e. work providing assistance to individuals and groups with issues such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, housing); or

(D) Three years of human services related experience (i.e., work providing assistance to individuals and groups with issues such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, housing).

(d) ELIGIBILITY SPECIALIST. An eligibility specialist must have knowledge of the public service system for developmental disability services in Oregon and at least:

(A) A bachelor's degree in behavioral science, social science, or a closely related field; or

(B) A bachelor's degree in any field and one year of human services related experience; or

(C) An associate's degree in behavioral science, social science, or a closely related field and two years of human services related experience; or

(D) Three years of human services related experience.

(e) ABUSE INVESTIGATOR SPECIALIST. An abuse investigator specialist must have at least:

(A) A bachelor's degree in human, social, behavioral, or criminal science and two years of human services, law enforcement, or investigative experience; or

(B) An associate's degree in human, social, behavioral, or criminal science and four years of human services, law enforcement, or investigative experience.

(5) EMPLOYMENT. An application for employment at the CDDP must inquire whether an applicant has had any founded reports of child abuse or substantiated abuse.

(6) BACKGROUND CHECKS.

(a) Any employee, volunteer, advisor of the CDDP, or any subject individual defined by OAR 407-007-0210 including staff who are not identified in this rule but use public funds intended for the operation of the CDDP, and who has or will have contact with an eligible individual of the CDDP, must have an approved background check in accordance with OAR 407-007-0200 to 407-007-0370 and under ORS 181.534.

(A) Effective July 28, 2009, the CDDP may not use public funds to support, in whole or in part, any employee, volunteer, advisor of the CDDP, or any subject individual defined by OAR 407-007-0210 who will have contact with a recipient of CDDP services and who has been convicted of any of the disqualifying crimes listed in OAR 407-007-0275.

(B) Effective July 28, 2009, a person does not meet the qualifications described in this rule if the person has been convicted of any of the disqualifying crimes listed in OAR 407-007-0275.

(C) Any employee, volunteer, advisor of the CDDP, or any subject individual defined by OAR 407-007-0210 must self-report any potentially disqualifying condition as described in OAR 407-007-0280 and OAR 407-007-0290. The person must notify the Department or the Department's designee within 24 hours.

(b) Subsections (A) and (B) of section (a) do not apply to employees who were hired prior to July 28, 2009 and remain in the current position for which the employee was hired.

(7) VARIANCE. The CDDP must submit a written variance request to the Department prior to employment of a person not meeting the minimum qualifications in section (4) of this rule. A variance request may not be requested for sections (5) and (6) of this rule. The written variance request must include:

(a) An acceptable rationale for the need to employ a person who does not meet the minimum qualifications in section (4) of this rule; and

(b) A proposed alternative plan for education and training to correct the deficiencies.

(A) The proposal must specify activities, timelines, and responsibility for costs incurred in completing the alternative plan.

(B) A person who fails to complete the alternative plan for education and training to correct the deficiencies may not fulfill the requirements for the qualifications.

(8) STAFF DUTIES.

(a) SERVICES COORDINATOR DUTIES. The duties of the services coordinator must be specified in the employee's job description and at a minimum include:

(A) The delivery of case management services to individuals as described in OAR 411-320-0090;

(B) Assisting the CDDP manager in monitoring the quality of services delivered within the county; and

(C) Assisting the CDDP manager in the identification of existing and insufficient service delivery resources or options.

(b) ELIGIBILITY SPECIALIST DUTIES. The duties of the eligibility specialist must be specified in the employee's job description and at a minimum include:

(A) Completing intake and eligibility determination for individuals applying for developmental disability services;

(B) Completing eligibility redetermination for individuals requesting continuing developmental disability services; and

(C) Assisting the CDDP manager in the identification of existing and insufficient service delivery resources or options.

(c) ABUSE INVESTIGATOR SPECIALIST DUTIES. The duties of the abuse investigator specialist must be specified in the employee's job description and at a minimum include:

(A) Conducting abuse investigation and protective services for adult individuals with intellectual or developmental disabilities enrolled in, or previously eligible and voluntarily terminated from, developmental disability services;

(B) Assisting the CDDP manager in monitoring the quality of services delivered within the county; and

(C) Assisting the CDDP manager in the identification of existing and insufficient service delivery resources or options.

(9) STAFF TRAINING. Qualified staff of the CDDP must maintain and enhance their knowledge and skills through participation in education and training. The Department provides training materials and the provision of training may be conducted by the Department or CDDP staff, depending on available resources.

(a) CDDP MANAGER TRAINING. The CDDP manager must participate in a basic training sequence and be knowledgeable of the duties of the staff they supervise and the developmental disability services they manage. The basic training sequence is not a substitute for the normal procedural orientation that must be provided by the CDDP to the new CDDP manager.

(A) The orientation provided by the CDDP to a new CDDP manager must include:

(i) An overview of developmental disability services and related human services within the county;

(ii) An overview of the Department's rules governing the CDDP;

(iii) An overview of the Department's licensing and certification rules for service providers;

(iv) An overview of the enrollment process and required documents needed for enrollment into the Department's payment and reporting systems;

(v) A review and orientation of Medicaid, Supplemental Security Income (SSI), Social Security Administration (SS), home and community-based waivered and state plan services, the Oregon Health Plan (OHP), and the individual support planning processes; and

(vi) A review (prior to having contact with individuals) of the CDDP manager's responsibility as a mandatory reporter of abuse, including abuse of individuals with intellectual or developmental disabilities, individuals with mental illness, older adults, and children.

(B) The CDDP manager must attend the following trainings endorsed or sponsored by the Department within the first year of entering into the position:

(i) Case management basics; and

(ii) ISP training.

(C) The CDDP manager must continue to enhance his or her knowledge, as well as maintain a basic understanding of developmental disability services and the skills, knowledge, and responsibilities of the staff they supervise.

(i) Each CDDP manager must participate in a minimum of 20 hours per year of additional Department-sponsored training or other training in the areas of intellectual or developmental disabilities.

(ii) Each CDDP manager must attend trainings to maintain a working knowledge of system changes in the area the CDDP manager is managing or supervising.

(b) CDDP SUPERVISOR TRAINING. The CDDP supervisor (when designated) must participate in a basic training sequence and be knowledgeable of the duties of the staff they supervise and of the developmental disability services they manage. The basic training sequence is not a substitute for the normal procedural orientation that must be provided by the CDDP to the new CDDP supervisor.

(A) The orientation provided by the CDDP to a new CDDP supervisor must include:

(i) An overview of developmental disability services and related human services within the county;

(ii) An overview of the Department's rules governing the CDDP;

(iii) An overview of the Department's licensing and certification rules for service providers;

(iv) An overview of the enrollment process and required documents needed for enrollment into the Department's payment and reporting systems;

(v) A review and orientation of Medicaid, SSI, SS, home and community-based waivered and state plan services, OHP, and the individual support planning processes; and

(vi) A review (prior to having contact with individuals) of the CDDP supervisor's responsibility as a mandatory reporter of abuse, including abuse of individuals with intellectual or developmental disabilities, individuals with mental illness, older adults, and children.

(B) The CDDP supervisor must attend the following trainings endorsed or sponsored by the Department within the first year of entering into the position:

(i) Case management basics; and

(ii) ISP training.

(C) The CDDP supervisor must continue to enhance his or her knowledge, as well as maintain a basic understanding of developmental disability services and the skills, knowledge, and responsibilities of the staff they supervise.

(i) Each CDDP supervisor must participate in a minimum of 20 hours per year of additional Department-sponsored training or other training in the areas of intellectual or developmental disabilities.

(ii) Each CDDP supervisor must attend trainings to maintain a working knowledge of system changes in the area the CDDP supervisor is managing or supervising.

(c) SERVICES COORDINATOR TRAINING. The services coordinator must participate in a basic training sequence. The basic training sequence is not a substitute for the normal procedural orientation that must be provided by the CDDP to the new services coordinator.

(A) The orientation provided by the CDDP to a new services coordinator must include:

(i) An overview of the role and responsibilities of a services coordinator;

(ii) An overview of developmental disability services and related human services within the county;

(iii) An overview of the Department's rules governing the CDDP;

(iv) An overview of the Department's licensing and certification rules for service providers;

(v) An overview of the enrollment process and required documents needed for enrollment into the Department's payment and reporting systems;

(vi) A review and orientation of Medicaid, SSI, SS, home and community-based waivered and state plan services, OHP, and the individual support planning processes for the services they coordinate; and

(vii) A review (prior to having contact with individuals) of the services coordinator's responsibility as a mandatory reporter of abuse, including abuse of individuals with intellectual or developmental disabilities, individuals with mental illness, seniors, and children.

(B) The services coordinator must attend the following trainings endorsed or sponsored by the Department within the first year of entering into the position:

(i) Case management basics; and

(ii) ISP training (for services coordinators providing services to individuals in comprehensive services).

(C) The services coordinator must continue to enhance his or her knowledge, as well as maintain a basic understanding of developmental disability services and the skills, knowledge, and responsibilities necessary to perform the position. Each services coordinator must participate in a minimum of 20 hours per year of Department-sponsored training or other training in the areas of intellectual or developmental disabilities.

(d) ELIGIBILITY SPECIALIST TRAINING. The eligibility specialist must participate in a basic training sequence. The basic training sequence is not a substitute for the normal procedural orientation that must be provided by the CDDP to the new eligibility specialist.

(A) The orientation provided by the CDDP to a new eligibility specialist must include:

(i) An overview of eligibility criteria and the intake process;

(ii) An overview of developmental disability services and related human services within the county;

(iii) An overview of the Department's rules governing the CDDP;

(iv) An overview of the Department's licensing and certification rules for service providers;

(v) An overview of the enrollment process and required documents needed for enrollment into the Department's payment and reporting systems;

(vi) A review and orientation of Medicaid, SSI, SS, home and community-based waivered or state plan services, and OHP; and

(vii) A review (prior to having contact with individuals) of the eligibility specialist's responsibility as a mandatory reporter of abuse, including abuse of individuals with intellectual or developmental disabilities, individuals with mental illness, seniors, and children.

(B) The eligibility specialist must attend and complete eligibility core competency training within the first year of entering into the position and demonstrate competency after completion of core competency training. Until completion of eligibility core competency training, or if competency is not demonstrated, the eligibility specialist must consult with another trained eligibility specialist or consult with a Department diagnosis and evaluation coordinator when making eligibility determinations.

(C) The eligibility specialist must continue to enhance his or her knowledge, as well as maintain a basic understanding of the skills, knowledge, and responsibilities necessary to perform the position.

(i) Each eligibility specialist must participate in Department-sponsored trainings for eligibility on an annual basis.

(ii) Each eligibility specialist must participate in a minimum of 20 hours per year of Department-sponsored training or other training in the areas of intellectual or developmental disabilities.

(e) ABUSE INVESTIGATOR SPECIALIST TRAINING. The abuse investigator specialist must participate in core competency training. Training materials are provided by the OAPPI. The core competency training is not a substitute for the normal procedural orientation that must be provided by the CDDP to the new abuse investigator specialist.

(A) The orientation provided by the CDDP to a new abuse investigator specialist must include:

(i) An overview of developmental disability services and related human services within the county;

(ii) An overview of the Department's rules governing the CDDP;

(iii) An overview of the Department's licensing and certification rules for service providers;

(iv) A review and orientation of Medicaid, SSI, SS, home and community-based waivered and state plan services, OHP, and the individual support planning processes; and

(v) A review (prior to having contact with individuals) of the abuse investigator specialist's responsibility as a mandatory reporter of abuse, including abuse of individuals with intellectual or developmental disabilities, individuals with mental illness, seniors, and children.

(B) The abuse investigator specialist must attend and pass core competency training within the first year of entering into the position and demonstrate competency after completion of core competency training. Until completion of core competency training, or if competency is not demonstrated, the abuse investigator specialist must consult with OAPPI prior to completing the abuse investigation and protective services report.

(C) The abuse investigator specialist must continue to enhance his or her knowledge, as well as maintain a basic understanding of the skills, knowledge, and responsibilities necessary to perform the position. Each abuse investigator specialist must participate in quarterly meetings held by OAPPI. At a minimum, one meeting per year must be attended in person.

(f) ATTENDANCE. The CDDP manager must assure the attendance of the CDDP supervisor, services coordinator, eligibility specialist, or abuse investigator specialist at Department-mandated training.

(g) DOCUMENTATION. The CDDP must keep documentation of required training in the personnel files of the individual employees including the CDDP manager, CDDP supervisor, services coordinator, eligibility specialist, abuse investigator specialist, and other employees providing services to individuals.

(10) ADVISORY COMMITTEE. Each CDDP must have an advisory committee.

(a) The advisory committee must meet at least quarterly.

(b) The membership of the advisory committee must be broadly representative of the community, with a balance of age, sex, ethnic, socioeconomic, geographic, professional, and consumer interests represented. Membership must include advocates for individuals as well as individuals and their families.

(c) The advisory committee must advise the LMHA, the CDDP director, and the CDDP manager on community needs and priorities for services, and assist in planning, reviewing, and evaluating services, functions, duties, and quality assurance activities described in the CDDP's management plan.

(d) When the Department or a private corporation is operating the CDDP, the advisory committee must advise the LMHA, the CDDP director, and the CDDP manager on community needs and priorities for services, and assist in planning, reviewing, and evaluating services, functions, duties, and quality assurance activities described in the CDDP's management plan.

(e) The advisory committee may function as the disability issues advisory committee as described in ORS 430.625 if so designated by the LMHA.

(11) NEEDS ASSESSMENT, PLANNING, AND COORDINATION. Upon the Department's request, the CDDP must assess local needs for services to individuals and must submit planning and assessment information to the Department.

(12) CONTRACTS.

(a) If the CDDP, or any of the CDDPs services as described in the Department's contract with the LMHA, is not operated by the LMHA, there must be a contract between the LMHA and the organization operating the CDDP or the services, or a contract between the Department and the operating CDDP. The contract must specify the authorities and responsibilities of each party and conform to the requirements of the Department's rules pertaining to contracts or any contract requirement with regard to operation and delivery of services.

(b) The CDDP may purchase certain services for an individual from a qualified service provider without first providing an opportunity for com-

petition among other service providers if the service provider is selected by the individual, the individual's family, or the individual's guardian or legal representative.

(A) The service provider selected must also meet Department certification or licensing requirements to provide the type of service to be contracted.

(B) There must be a contract between the service provider and the CDDP that specifies the authorities and responsibilities of each party and conforms to the requirements of the Department's rules pertaining to contracts or any contract requirement with regard to operation and delivery of services.

(c) When a CDDP contracts with a public agency or private corporation for delivery of developmental disability services, the CDDP must include in the contract only terms that are substantially similar to model contract terms established by the Department. The CDDP may not add contractual requirements, including qualifications for contractor selection that are nonessential to the services being provided under the contract. The CDDP must specify in contracts with service providers that disputes arising from these limitations must be resolved according to the complaint procedures contained in OAR 411-320-0170. For purposes of this rule, the following definitions apply:

(A) "Model contract terms established by the Department" means all applicable material terms and conditions of the omnibus contract, as modified to appropriately reflect a contractual relationship between the service provider and CDDP and any other requirements approved by the Department as local options under procedures established in these rules.

(B) "Substantially similar to model contract terms" means that the terms developed by the CDDP and the model contract terms require the service provider to engage in approximately the same type activity and expend approximately the same resources to achieve compliance.

(C) "Nonessential to the services being provided" means requirements that are not substantially similar to model contract terms developed by the Department.

(d) The CDDP may, as a local option, impose on a public agency or private corporation delivering developmental disability services under a contract with the CDDP, a requirement that is in addition to or different from requirements specified in the omnibus contract if all of the following conditions are met:

(A) The CDDP has provided the affected contractors with the text of the proposed local option as it would appear in the contract. The proposed local option must include:

(i) The date upon which the local option would become effective and a complete written description of how the local option would improve individual independence, productivity, or integration; or

(ii) How the local option would improve the protection of individual health, safety, or rights;

(B) The CDDP has sought input from the affected contractors concerning ways the proposed local option impacts individual services;

(C) The CDDP, with assistance from the affected contractors, has assessed the impact on the operations and financial status of the contractors if the local option is imposed;

(D) The CDDP has sent a written request for approval of the proposed local option to the Department's Director that includes:

(i) A copy of the information provided to the affected contractors;

(ii) A copy of any written comments and a complete summary of oral comments received from the affected contractors concerning the impact of the proposed local option; and

(iii) The text of the proposed local option as it would appear in contracts with service providers, including the proposed date upon which the requirement would become effective.

(E) The Department has notified the CDDP that the new requirement is approved as a local option for that program; and

(F) The CDDP has advised the affected contractors of their right and afforded them an opportunity to request mediation as provided in these rules before the local option is imposed.

(e) The CDDP may add contract requirements that the CDDP considers necessary to ensure the siting and maintenance of residential facilities in which individual services are provided. These requirements must be consistent with all applicable state and federal laws and regulations related to housing.

(f) The CDDP must adopt a dispute resolution policy that pertains to disputes arising from contracts with service providers funded by the Department and contracted through the CDDP. Procedures implementing the dispute resolution policy must be included in the contract with any such service provider.

(13) FINANCIAL MANAGEMENT.

(a) There must be up-to-date accounting records for each developmental disability service accurately reflecting all revenue by source, all expenses by object of expense, and all assets, liabilities, and equities. The accounting records must be consistent with generally accepted accounting principles and conform to the requirements of OAR 309-013-0120 to 309-013-0220.

(b) There must be written statements of policy and procedure as are necessary and useful to assure compliance with any Department administrative rules pertaining to fraud and embezzlement and financial abuse or exploitation of individuals.

(c) Billing for Title XIX funds must in no case exceed customary charges to private pay individuals for any like item or service.

(14) POLICIES AND PROCEDURES. There must be such other written and implemented statements of policy and procedure as necessary and useful to enable the CDDP to accomplish its service objectives and to meet the requirements of the contract with the Department, these rules, and other applicable standards and rules.

Stat. Auth.: ORS 409.050, 410.070, & 430
Stats. Implemented: ORS 427.005, 427.007, 430.610 - 430.695
Hist.: SPD 24-2003, f. 12-29-03, cert. ef. 1-1-04; SPD 28-2004, f. & cert. ef. 8-3-04; SPD 16-2005(Temp), f. & cert. ef. 11-23-05 thru 5-22-06; SPD 5-2006, f. 1-25-06, cert. ef. 2-1-06; SPD 9-2009, f. & cert. ef. 7-13-09; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 2-2010(Temp), f. & cert. ef. 3-18-10 thru 6-30-10; SPD 5-2010, f. 6-29-10, cert. ef. 7-1-10; SPD 27-2010Temp), f. & cert. ef. 12-1-10 thru 5-30-11; SPD 11-2011, f. & cert. ef. 6-2-11; SPD 22-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-320-0040
Community Developmental Disability Program Responsibilities

The CDDP must ensure the provision of the following services and system supports.

(1) ACCESS TO SERVICES.

(a) In accordance with the Civil Rights Act of 1964 (codified as 42 USC 2000d et seq.), any person may not be denied community developmental disability services on the basis of race, color, creed, sex, national origin, or duration of residence. CDDP contractors must comply with Section 504 of the Rehabilitation Act of 1973 (codified as 29 USC 794 and as implemented by 45 CFR Section 84.4) that states in part, "No qualified person must, on the basis of handicap, be excluded from participation in, be denied benefits of, or otherwise be subjected to discrimination under any program or activity that receives or benefits from federal financial assistance".

(b) Any individual determined eligible for developmental disability services by a CDDP must also be eligible for other community developmental disability services unless admission to the service is subject to diagnostic or developmental disability category or age restrictions based on predetermined criteria or contract limitations.

(2) COORDINATION OF COMMUNITY SERVICES. Planning and implementation of services for individuals served by the CDDP must be coordinated between components of the CDDP, other local and state human service agencies, and any other service providers as appropriate for the needs of the individual.

(3) CHOICE COUNSELING. Effective July 1, 2013, choice counseling regarding the provision of case management and other services must be provided to individuals who are eligible for and desire developmental disability services. Choice counseling is provided by a choice advisor who impartially describes service delivery options available through a support services brokerage or CDDP. Choice counseling is provided on an annual basis.

(4) CASE MANAGEMENT SERVICES.

(a) The CDDP may provide case management to individuals who are waiting for a determination of eligibility and reside in the county at the time they apply.

(b) Case management may be provided directly by the CDDP or under a contract between the CDDP and a service provider of case management services.

(c) If an individual is receiving services in more than one county, the county of origin must be responsible for case management services unless otherwise negotiated and documented in writing with the mutually agreed upon conditions.

(d) Case management services require an impartial point of view to fulfill the necessary functions of planning, procuring, monitoring, and investigating. Except as allowed under section (4)(e) of this rule, the case management program must be provided under an organizational structure that separates case management from other direct services for individuals. This separation may take one of the following forms:

(A) The CDDP may provide case management and subcontract for delivery of other direct services through one or more different organizations; or

(B) The CDDP may subcontract for delivery of case management through an unrelated organization and directly provide the other services, or further subcontract these other direct services through organizations that are not already under contract to provide case management services.

(e) A CDDP or other organization that provides case management services may also provide other direct services under the following circumstances:

(A) The CDDP coordinates the delivery of family support services for children under 18 years of age living at home with their family or comprehensive in-home supports for adults.

(B) The CDDP determines that an organization providing direct services is no longer able to continue providing services, or the organization providing direct service is no longer willing or able and no other organization is able or willing to continue operations on 30 days notice.

(C) In order to develop new or expanded direct services for geographic service areas or populations because other local organizations are unwilling or unable to provide appropriate services.

(f) A variance must be prior authorized by the Department if a CDDP intends to perform a direct service other than family support services or comprehensive in-home support.

(A) It is assumed that the CDDP provides family support services or comprehensive in-home supports described in subsection (e)(A) of this section. If the CDDP does not provide one or both of these services, the CDDP must submit a written variance request to the Department for prior approval that describes how the services are provided.

(B) If the circumstance described in subsection (e)(B) of this rule exist, the CDDP must propose a plan to the Department for review including action to assume responsibility for case management services and the mechanism for addressing potential conflict of interest.

(C) If a CDDP providing case management services delivers other services as allowed under subsection (e)(C) of this section, the organization must submit a written variance request to the Department for prior approval that includes the action to assume responsibility for case management services and the mechanism for addressing potential conflict of interest.

(g) If an organization providing case management services delivers other services as allowed under subsections (e)(B) and (e)(C) of this rule, the organization must solicit other organizations to assume responsibility for delivery of these other services through a request for proposal (RFP) at least once every two years. When an RFP is issued, a copy must be sent to the Department. The Department must be notified of the results of the solicitation, including the month and year of the next solicitation if there are no successful applicants.

(h) If the CDDP wishes to continue providing case management and other direct services without conducting a solicitation as described in subsection (g) of this section, the CDDP must submit a written variance request to the Department for prior approval that describes how conflict of roles are managed within the CDDP.

(i) If the CDDP also operates a support services brokerage, the CDDP must submit a written variance request to the Department for prior approval that includes the mechanism for addressing potential conflict of interest.

(5) FAMILY SUPPORT. The CDDP must ensure the availability of a program for family support services in accordance with OAR chapter 411, division 305.

(6) ABUSE AND PROTECTIVE SERVICES. The CDDP must assure that abuse investigations for adults with intellectual or developmental disabilities are appropriately reported and conducted by trained staff according to statute and administrative rules. When there is reason to believe a crime has been committed, the CDDP must report to law enforcement. The CDDP must report any suspected or observed abuse of children directly to the Department or local law enforcement, when appropriate.

(7) FOSTER HOMES. The CDDP must recruit foster home applicants and maintain forms and procedures necessary to license or certify foster homes. The CDDP must maintain copies of the following records:

(a) Initial and renewal applications for a foster home;

(b) All inspection reports completed by the CDDP (including required annual renewal inspection and any other inspections);

(c) General information about the home;

(d) Documentation of references, classification information, credit check (if necessary), background check, and training for service providers and substitute caregivers;

(e) Documentation of foster care exams for adult foster home providers;

(f) Correspondence;

(g) Any meeting notes;

(h) Financial records;

(i) Annual agreement or contract;

(j) Legal notices and final orders for rule violations, conditions, denials, or revocations (if any); and

(k) Copies of the foster home's annual license or certificate.

(8) CONTRACT MONITORING. The CDDP must monitor all community developmental disability subcontractors to assure that:

(a) Services are provided as specified in the CDDP's contract with the Department; and

(b) Services are in compliance with these rules and other applicable Department rules.

(9) INFORMATION AND REFERRAL. The CDDP must provide information and referral services to individuals, individuals' families, and interested others.

(10) AGENCY COORDINATION. The CDDP must assure coordination with other agencies to develop and manage resources within the county or region to meet the needs of individuals.

(11) MAINTENANCE OF CENTRALIZED WAIT LIST. The CDDP must maintain a current unduplicated central wait list as described in OAR 411-320-0090 of eligible individuals 18 years and older living within the geographic service area of the CDDP who are enrolled in case management services and who are not receiving comprehensive services for adults.

(12) SERVICE DELIVERY COMPLAINTS. The CDDP must implement procedures to address individual or family complaints regarding service delivery that have not been resolved using the CDDP subcontractor's complaint procedures (informal or formal). Such procedures must be consistent with the requirements in OAR 411-320-0170.

(13) COMPREHENSIVE IN-HOME SUPPORTS. The CDDP must ensure the availability of comprehensive in-home supports for those individuals for whom the Department has funded such services. Comprehensive in-home support services must be in compliance with OAR chapter 411, division 330.

(14) EMERGENCY PLANNING. The CDDP must ensure the availability of a written emergency procedure and disaster plan for meeting all civil or weather emergencies and disasters. The emergency procedure and disaster plan must be immediately available to the CDDP manager and employees. The emergency procedure and disaster plan must:

(a) Be integrated with the county emergency preparedness plan where appropriate;

(b) Include provisions on coordination with all developmental disability service provider agencies in the county and any offices, as appropriate;

(c) Include provisions for identifying individuals most vulnerable; and

(d) Include any plans for health and safety checks, emergency assistance, and any other plans that are specific to the type of emergency.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409.050, 410.070, 430.640

Stats. Implemented: ORS 427.005, 427.007, 430.610 - 430.695

Hist.: SPD 24-2003, f. 12-29-03, cert. ef. 1-1-04; SPD 28-2004, f. & cert. ef. 8-3-04; SPD 16-2005(Temp), f. & cert. ef. 11-23-05 thru 5-22-06; SPD 5-2006, f. 1-25-06, cert. ef. 2-1-06; SPD 9-2009, f. & cert. ef. 7-13-09; SPD 22-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-320-0060

Rights of the Individual Receiving Developmental Disability Services

(1) CIVIL RIGHTS. The rights described in this rule are in addition to and do not limit any other statutory and constitutional rights that are afforded all citizens including but not limited to the right to vote, marry, have or not have children, own and dispose of property, and enter into contracts and execute documents unless specifically prohibited by law in the case of children under 18 years of age.

(2) RIGHTS OF INDIVIDUALS RECEIVING SERVICES. The CDDP must have written policies and procedures to provide for and assure individuals the following rights while receiving developmental disability services:

(a) The right to a humane service environment that affords reasonable protection from harm, affords reasonable privacy, and ensures that individuals:

(A) Are not abused or neglected, nor is abuse or neglect tolerated by any employee, staff, or volunteer of the program;

(B) Are free to report any incident of abuse without being subject to retaliation;

(C) Have the freedom to choose whether or not to participate in religious activity and for children, according to parent or guardian preference;

(D) Have contact and visits with legal and medical professionals unless prohibited by court order, family members, friends, and advocates;

(E) Have access to and communicate privately with any public or private rights protection program advocate, services coordinator, or CDDP representative;

(F) Be free from unauthorized mechanical restraint or protective physical intervention; and

(G) Are not subject to any chemical restraint and assured that medication is administered only for the individual's clinical needs as prescribed by a health care provider.

(b) Effective July 1, 2013, the right at any time, to choose from available services, available service settings, and available service providers consistent with the individual's service needs identified through a functional needs assessment. Services must promote independence, dignity, and self-esteem and reflect the age and preferences of the individual. The services must be provided in a setting and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual, and that provide for decision-making and control of personal affairs appropriate to the individual's age.

(c) The right to a written Individual Support Plan, services delivered according to the ISP, and periodic review and reassessment of the individual's support needs.

(d) The right to an ongoing opportunity to participate in planning of services in a manner appropriate to the individual's capabilities, including the right to participate in the development and periodic revision of the ISP described in subsection (c) of this section, and the right to be provided with a reasonable explanation of all service considerations.

(e) The right to informed voluntary written consent prior to receiving services except in a medical emergency or as otherwise permitted by law.

(f) The right to informed voluntary written consent prior to participating in any experimental programs.

(g) The right to prior notice of any action that would terminate, suspend, reduce, or deny a service and notification of other available sources for necessary continued services.

(h) The right to a hearing as defined in OAR 411-320-0020 following an action that would terminate, suspend, reduce, or deny a service.

(i) The right to reasonable and lawful compensation for performance of labor, except personal housekeeping duties.

(j) The right to exercise all rights set forth in ORS 426.385 and 427.031 if the individual is committed to the Department.

(k) The right to be informed at the start of services and periodically thereafter of the rights guaranteed by this rule and the procedures for reporting abuse.

(l) The right to have these rights and procedures prominently posted in a location readily accessible to the individual and made available to the individual's guardian and any representative designated by the individual.

(m) The right to be informed of and have the opportunity to assert complaints with respect to infringement of the rights described in this rule, including the right to have such complaints considered in a fair, timely, and impartial procedure.

(n) The right to have the freedom to exercise all rights described in this rule without any form of reprisal or punishment.

(o) The right to have the individual or the individual's guardian and any representative designated by the individual be informed that a family member has contacted the Department to determine the location of the individual and to be informed of the name and contact information, if known, of the family member.

(p) The right to courteous, fair, and dignified treatment by Department personnel and to file a complaint with the Department about staff conduct or customer service to the extent provided in OAR 407-005-0100 to 407-005-0120.

(q) The right to file a complaint with the Department about discrimination or unfair treatment as provided in OAR 407-005-0030.

(3) ASSERT RIGHTS. The rights described in this rule may be asserted and exercised by the individual, the individual's guardian, and any legal representative designated by the individual.

(4) CHILDREN. Nothing in this rule alters any legal rights and responsibilities between a parent and a child.

(5) ADULTS WITH GUARDIANS. Guardians are appointed for an adult only as is necessary to promote and protect the well being of the individual. A guardianship for an adult must be designed to encourage the development of maximum self-reliance and independence of the individual and may be ordered only to the extent necessitated by the individual's actual mental and physical limitations. An adult for whom a guardian has been appointed is not presumed to be incompetent. An individual with a guardian retains all legal and civil rights provided by law except those that have been expressly limited by court order or specifically granted to the guardian by the court. Rights retained by the individual include but are not limited to the right to contact and retain counsel and to have access to personal records as described in ORS 125.300.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409.050, 410.070, 430.640

Stats. Implemented: ORS 427.005, 427.007, 430.610 - 430.695

Hist.: SPD 24-2003, f. 12-29-03, cert. ef. 1-1-04; SPD 28-2004, f. & cert. ef. 8-3-04; SPD 5-2006, f. 1-25-06, cert. ef. 2-1-06; SPD 9-2009, f. & cert. ef. 7-13-09; SPD 22-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-320-0070

Records of Service

(1) CONFIDENTIALITY. Records of services to individuals must be kept confidential in accordance with ORS 179.505, ORS 192.515 to 192.518, 45 CFR 205.50, 45 CFR 164.512, Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2 HIPAA, and any Department rules or policies pertaining to individual service records.

(2) INFORMATION SHARING. Pertinent clinical, financial eligibility, and legal status information concerning an individual supported by the CDDP must be made available to other CDDP's responsible for the individual's services, consistent with state statutes and federal laws, and regulations concerning confidentiality and privacy.

(3) RECORD REQUIREMENT. In order to meet Department and federal record documentation requirements, the CDDP, through its employees, must maintain a record for each individual who receives services from the CDDP.

(a) Information contained in the record for all individuals receiving services from a services coordinator must include:

(A) Effective July 1, 2013, documentation of initial and annual choice counseling provided by a choice advisor as described in OAR 411-320-0100;

(B) Documentation of any initial referral to the CDDP for services;

(C) An application for developmental disability services. The application for developmental disability services must be completed prior to an eligibility determination and must be on the application form required by the Department or transferred onto CDDP letterhead;

(D) Sufficient documentation to conform to Department eligibility requirements including notices of eligibility determination;

(E) Documentation of an initial intake interview or home assessment, as well as any subsequent social service summaries;

(F) Effective July 1, 2013, documentation of a functional needs assessment defining support needs for activities of daily living and instrumental activities of daily living;

(G) Documentation of an individual's request for support services and the individual's selection of an available support services brokerage within the CDDP's geographic service area;

(H) Referral information or documentation of referral materials sent to a service provider or another CDDP;

(I) Progress notes written by a services coordinator;

(J) Medical information, as appropriate;

(K) Admission and exit meeting documentation into any comprehensive service including any transition plans, crisis diversion plans, or other plans developed as a result of the meeting;

(L) The ISP including documentation that the ISP is authorized by a services coordinator;

(M) Copies of any incident reports initiated by a CDDP representative for any incident that occurred at the CDDP or in the presence of the CDDP representative;

(N) Documentation of a review of unusual incidents received from service providers. Documentation of a review of unusual incidents must be made in progress notes and a copy of the incident report must be placed in the individual's file. If applicable, information must be electronically entered into the SERT system and referenced in progress notes;

(O) Documentation of Medicaid eligibility, if applicable;

(P) Initial and annual level of care assessment review on a form prescribed by the Department.;

(i) For individuals receiving children's intensive in-home services or children's 24-hour residential services, the CDDP must maintain a current copy of the annual level of care assessment review or reflect documentation of attempts to obtain a current copy.

(ii) Once the individual is enrolled in a support services brokerage, the CDDP must maintain a copy of the initial level of care assessment form completed by the CDDP and any annual reviews completed by the CDDP; and

(Q) Legal records, such as guardianship papers, civil commitment records, court orders, and probation and parole information, as appropriate.

(b) An information sheet or reasonable alternative must be kept current and reviewed at least annually for each individual receiving case management services from the CDDP enrolled in comprehensive services, family support services, or living with family or independently. Information must include:

(A) The individual's name, current address, date of entry into the program, date of birth, sex, marital status (for individuals 18 or older), religious preference, preferred hospital, medical prime number and private insurance number (where applicable), and guardianship status; and

(B) The names, addresses, and telephone numbers of:

(i) The individual's guardian or other legal representative, family, advocate or other significant person, and for children, the child's parent or guardian, and education surrogate, if applicable;

(ii) The individual's physician and clinic;

(iii) The individual's dentist;

(iv) The individual's school, day program, or employer, if applicable;

(v) Other agency representatives providing services to the individual; and

(vi) Any court ordered or legal representative authorized contacts or limitations from contact for individuals living in a foster home, supported living program, or 24-hour residential program.

(c) A current information sheet or reasonable alternative must be maintained for each individual enrolled in a support services brokerage. The current information must include the information listed in subsection (b) of this section.

(4) PROGRESS NOTES. Progress notes must include documentation of the delivery of service by a services coordinator to support provided case management services. Progress notes must be recorded chronologically and documented consistent with CDDP policies and procedures. All late entries must be appropriately documented. Progress notes must at a minimum include:

(a) The month, day, and year the services were rendered and the month, day, and year the entry was made if different from the date service was rendered;

(b) The name of the individual receiving service;

(c) The name of the CDDP, the person providing the service (i.e., the services coordinator's signature and title), and the date the entry was recorded and signed;

(d) The specific services provided and actions taken or planned, if any;

(e) Place of service. Place of service means the county where the CDDP or agency providing case management services is located, including the address. The place of service may be a standard heading on each page of the progress notes; and

(f) The names of other participants (including titles and agency representation, if any) in notes pertaining to meetings with or discussions about the individual.

(5) RETENTION OF RECORDS. The CDDP must have a record retention plan for all records relating to the CDDP's provision of and contracts for services that is consistent with this rule and OAR 166-150-0055. The record retention plan must be made available to the public or the Department upon request.

(a) Financial records, supporting documents, and statistical records must be retained for a minimum of three years after the close of the contract period, or until the conclusion of the financial settlement process with the Department, whichever is longer.

(b) Individual service records must be kept for seven years after the date of the individual's death, if known. If the case is closed, inactive, or death date is unknown, the individual service record must be kept for 70 years.

(c) Copies of annual ISPs must be kept for 10 years.

(6) TRANSFER OF RECORDS. In the event an individual moves from one county to another county in Oregon, the complete individual record as described in section (3) of this rule must be transferred to the receiving CDDP within 30 days of transfer. The sending CDDP must ensure that the records required by this rule are maintained in permanent record and transferred to the CDDP having jurisdiction for services. The sending CDDP must retain information necessary to document that services were provided to the individual while enrolled in CDDP services. This includes:

(a) Documentation of eligibility for developmental disability services received while enrolled in services through the CDDP including waiver or state plan eligibility;

(b) Service enrollment and termination forms, including comprehensive services wait list enrollment date if applicable;

(c) CDDP progress notes;

(d) Documentation of services provided to the individual by the CDDP; and

(e) Any required documentation necessary to complete the financial settlement with the state.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409.050, 410.070, 430.640

Stats. Implemented: ORS 427.005, 427.007, 430.610 - 430.695

Hist.: SPD 24-2003, f. 12-29-03, cert. ef. 1-1-04; SPD 28-2004, f. & cert. ef. 8-3-04; SPD 16-2005(Temp), f. & cert. ef. 11-23-05 thru 5-22-06; SPD 5-2006, f. 1-25-06, cert. ef. 2-1-06; SPD 9-2009, f. & cert. ef. 7-13-09; SPD 22-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-320-0090

Developmental Disabilities Case Management Program Responsibilities

(1) AVAILABILITY. As required by these rules, the CDDP must assure the availability of a services coordinator to meet the service needs of an individual and any emergencies or crisis. The assignment of the services coordinator must be appropriately documented in an individual's service records and the CDDP must accurately report enrollment in the Department's payment and reporting systems.

(2) POLICIES AND PROCEDURES. The CDDP must adopt written procedures to assure that the delivery of services meet the standards in section (4) of this rule.

(a) The CDDP must have procedures for ongoing involvement of individuals and family members in the planning and review of consumer satisfaction with the delivery of case management or direct services provided by the CDDP.

(b) Copies of the procedures for planning and review of case management services, consumer satisfaction, and complaints must be maintained on file at the CDDP offices. The procedures must be available to:

(A) CDDP employees who work with individuals;

(B) Individuals who are receiving services from the CDDP and the individuals' families;

(C) Individuals' legal representatives, advocates, and service providers; and

(D) The Department.

(3) NOTICE OF SERVICES. The CDDP must inform the individuals, family members, legal representatives, and advocates of the minimum case management services that are set out in section (4) of this rule.

(4) MINIMUM STANDARDS FOR CASE MANAGEMENT SERVICES.

(a) The CDDP must ensure that eligibility for services is determined by an eligibility specialist trained in accordance with OAR 411-320-0030.

(b) An ISP for an individual receiving case management services through a CDDP must be developed and reviewed in accordance with OAR 411-320-0120.

(A) The services coordinator must assure that there is an ISP. The services coordinator must attend the annual ISP meeting and facilitate the development of the ISP for individuals enrolled in comprehensive services. The services coordinator is responsible for the development of the ISP for children receiving family support services in coordination with the child and the child's family.

(B) An Annual Plan must be completed for each individual that is not enrolled in any Department-funded service other than case management.

(c) Program services must be authorized in accordance with OAR 411-320-0120.

(d) Services coordinators must monitor services and supports for all individuals enrolled in case management services through a CDDP in accordance with the standards described in OAR 411-320-0130.

(e) If an individual loses OSIP-M eligibility and the individual is receiving case management services through the CDDP, the services coordinator must assist the individual in identifying why OSIP-M eligibility was lost. Whenever possible, the services coordinator must assist the individual in becoming eligible for OSIP-M again. The services coordinator must document efforts taken to assist the individual in becoming OSIP-M eligible in the individual's service record.

(f) Entry, exit, and transfers from comprehensive program services must be in accordance with OAR 411-320-0110.

g) Crisis diversion services for individuals receiving case management services through a CDDP must be assessed, identified, planned, monitored, and evaluated by the services coordinator in accordance with OAR 411-320-0160.

(h) Abuse investigations and provision of protective services for adults must be provided as described in OAR 407-045-0250 to 407-045-0360 and include investigating complaints of abuse, writing investigation reports, and monitoring for implementation of report recommendations.

(i) Civil commitment services must be provided in accordance with ORS 427.215 to 427.306.

(j) Individuals determined eligible for developmental disability services or moving into a county with an existing eligibility determination must be referred to a choice advisor within 10 days. A choice advisor describes case management and other service delivery options within the CDDP's geographic services area provided by a CDDP or support services brokerage.

(A) For individuals 18 years and older, choice counseling must specifically include information necessary to inform the individual of support services.

(B) For individuals 18 years and older, choice counseling must be provided initially and at minimum annually thereafter if the individual declines support services. Annual information and referral must include informing the individual of the individual's right to, at any time, request access to support services. Documentation of the initial referral and subsequent annual discussion must be documented in the individual's service record.

(C) For individuals who are not eligible for Community First Choice State Plan or waivered services, initial and annual choice counseling must also include information to inform the individual of their right to access the comprehensive services waitlist at anytime.

(k) For individuals who are not eligible for Community First Choice State Plan or waivered services, the services coordinator must enroll individuals in the comprehensive services wait list who meet the following criteria:

(A) The individual is age 18 or older;

(B) The individual is enrolled in case management services;

(C) The individual has requested to be enrolled in the comprehensive services wait list; and

(D) The individual is not enrolled in comprehensive services as an adult.

(l) An individual who moves between CDDP's and whose case management or support services do not lapse for more than a period of 12 months retains the wait list enrollment date assigned or continued by the CDDP in which case management services were previously received. If an individual did not receive case management services in any county in Oregon for a period exceeding 12 calendar months, a new wait list enrollment date is assigned. The new wait list enrollment date must be the date the individual first meets all the criteria described in OAR subsection (k) of this section.

(m) When funding and resources are available, the CDDP must facilitate selection of individuals from the comprehensive services wait list using the date of enrollment on the comprehensive services wait list. An individual not eligible for Community First Choice State Plan or waivered services, but is in crisis according to OAR 411-320-0160 and in need of service must be given first consideration for comprehensive services regardless of the date of enrollment on the comprehensive services wait list.

(n) The services coordinator may remove an individual from the comprehensive services wait list for the following reasons:

(A) The individual requests to be removed;

(B) The individual is placed in comprehensive services; or

(C) Upon the individual's exit or termination from case management services or a support services brokerage.

(o) The CDDP must inform the individual of the CDDP's intent to remove the individual from the comprehensive services wait list.

(p) Services coordinators must coordinate services with the child welfare (CW) caseworker assigned to a child to ensure the provision of required supports from the Department, CDDP, and CW.

(q) Services coordinators may attend IEP planning meetings or other transition planning meetings for children when the services coordinator is invited by the family or guardian to participate.

(A) The services coordinator may, to the extent resources are available, assist the family in accessing those critical non-educational services that the child or family may need.

(B) Upon request and to the extent possible, the services coordinator may act as a proponent for the child or family at IEP meetings.

(C) The services coordinator must participate in transition planning by attending IEP meetings or other transition planning meetings for students 16 years of age or older, or until the student is enrolled in the support services brokerage, to discuss the individual's transition to adult living and work situations unless such attendance is refused by the child's parent or legal guardian, or the individual if the individual is 18 years or older.

(r) The CDDP must ensure individuals eligible for and receiving developmental disability services are enrolled in the Department's payment and reporting systems. The county of origin must enroll the individual into the Department payment and reporting systems for all developmental disability service providers except in the following circumstances:

(A) The Department completes the enrollment or termination form for children entering or leaving a licensed 24-hour residential program that is directly contracted with the Department.

(B) The Department completes the Department payment and reporting systems enrollment, termination, and billing forms for children entering or leaving the children's intensive in-home services (CIIS) program.

(C) The Department completes the enrollment, termination, and billing forms as part of an interagency agreement for purposes of billing for crisis diversion services by a region.

(s) Services coordinators must facilitate referrals to nursing facilities when appropriate as described in OAR 411-070-0043.

(t) The services coordinator must coordinate and monitor the specialized services provided to an eligible individual living in a nursing facility in accordance with OAR 411-320-0150.

(u) The services coordinator must ensure that all serious events related to an individual are reported to the Department using the SERT system. The CDDP must ensure that there is monitoring and follow-up on both individual events and system trends.

(v) When the services coordinator completes the level of care assessment, the services coordinator must ensure that Medicaid eligible individuals are offered the choice of home and community-based waivered or state plan services, provided a notice of hearing rights, and have a completed level of care assessment that is reviewed annually or at anytime there is a significant change. For individuals who are expected to enter support services, the services coordinator must complete the initial level of care assessment after the individual's 18th birth date and no more than 30 days prior to entry into the support services brokerage. The support services brokerage staff must assess the individual's level of care annually thereafter for continued Medicaid waiver and state plan eligibility or at anytime there are significant changes.

(w) The services coordinator must participate in the appointment of a health care representative as described in OAR chapter 411, division 365.

(x) The services coordinator must coordinate with other state, public, and private agencies regarding services to individuals.

(y) The CDDP must ensure that a services coordinator is available to provide or arrange for comprehensive in-home supports for adults, long term supports for children, or family supports, as required, to meet the support needs of eligible individuals. This includes:

(A) Providing assistance in determining needs and planning supports;

(B) Providing assistance in finding and arranging resources and supports;

(C) Providing education and technical assistance to make informed decisions about support need and direct support service providers;

(D) Arranging fiscal intermediary services;

(E) Arranging employer-related supports; and

(F) Providing assistance with monitoring and improving the quality of supports.

(5) SERVICE PRIORITIES. If it becomes necessary for the CDDP to prioritize the availability of case management services, the CDDP must request and have approval of a variance prior to implementation of any alternative plan. If the reason for the need for the variance could not have been reasonably anticipated by the CDDP, the CDDP has 15 working days to submit the variance request to the Department. The variance request must:

(a) Document the reason the service prioritization is necessary (including any alternatives considered);

(b) Detail the specific service priorities being proposed; and

(c) Provide assurances that the basic health and safety of individuals must continue to be addressed and monitored.

(6) FAMILY RECONNECTION. The CDDP and the services coordinator must provide assistance to the Department when a family member is attempting to reconnect with an individual who was previously discharged from Fairview Training Center or Eastern Oregon Training Center or the individual is currently receiving developmental disability services.

(a) If a family member contacts a CDDP for assistance in locating a family member they must be referred to the Department. A family member may contact the Department directly.

(b) The Department sends the family member a Department form requesting further information to be used in providing notification to the individual. The form includes the following information:

(A) Name of requestor;

(B) Address of requestor and other contact information;

(C) Relationship to individual;

(D) Reason for wanting to reconnect; and

(E) Last time the family had contact.

(c) The Department determines if the individual was previously a resident of Fairview Training Center or Eastern Oregon Training Center and also determines:

(A) If the individual is deceased or living;

(B) Whether the individual is currently or previously enrolled in Department services; and

(C) The county in which services are being provided, if applicable.

(d) Within 10 working days of receipt of the request, the Department notifies the family member if the individual is enrolled or no longer enrolled in Department services.

(e) If the individual is enrolled in Department services, the Department sends the completed family information form to the individual or the individual's guardian and the individual's services coordinator.

(f) If the individual is deceased, the Department follows the process for identifying the individual's personal representative as provided for in ORS 192.526.

(A) If the personal representative and the requesting family member are the same, the family member must be informed that the person is deceased.

(B) If the personal representative is different from the requesting family member, the personal representative must be contacted for permission before sharing the information to the requesting family member. The Department must make a good faith effort at finding the personal representative and obtaining a decision concerning the sharing of information as soon as practicable.

(g) When an individual is located, a meeting with the individual or the individual's guardian to discuss and determine if the individual wishes to have contact with the family member is facilitated by the individual's services coordinator or personal agent, as applicable.

(A) The services coordinator or the CDDP in conjunction with the personal agent must assist the individual or the individual's guardian in evaluating the information to make a decision regarding initiating contact including providing the information from the form and any relevant history with the family member that might support contact or present a risk to the individual.

(B) If the individual does not have a guardian or is unable to express his or her wishes, the individual's ISP team must be convened to review factors and choose the best response for the individual after evaluating the situation.

(h) If the individual or the individual's guardian wishes to have contact, the individual or ISP team designee may directly contact the family member to make arrangements for the contact.

(i) If the individual or the individual's guardian does not wish to have contact, the services coordinator or personal agent, as applicable, must notify the Department. The Department shall inform the family member in writing that no contact is requested.

(j) The notification to the family member regarding the decision of the individual or the individual's guardian must be within 60 business days of the receipt of the information form from the family member.

(k) The decision by the individual or the individual's guardian is not appealable.

Stat. Auth.: ORS 409.050, 410.070, 430.640

Stats. Implemented: ORS 427.005, 427.007, 430.610 - 430.695

Hist.: SPD 24-2003, f. 12-29-03, cert. ef. 1-1-04; SPD 28-2004, f. & cert. ef. 8-3-04; SPD 16-2005(Temp), f. & cert. ef. 11-23-05 thru 5-22-06; SPD 5-2006, f. 1-25-06, cert. ef. 2-1-06; SPD 9-2009, f. & cert. ef. 7-13-09; SPD 18-2011(Temp), f. & cert. ef. 7-1-11 thru 12-28-11; SPD 27-2011, f. & cert. ef. 12-28-11; SPD 22-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-320-0100

Assignment of Services Coordinator

(1) CHOICE COUNSELING AND DESIGNATION OF A SERVICES COORDINATOR OR PERSONAL AGENT.

(a) For individuals determined eligible for developmental disability services or moving into a county with an existing eligibility determination, a referral to a choice advisor must be made within 10 days.

(b) Within 15 days from the date of referral, the choice advisor must meet with the individual or legal representative to determine whether the individual chooses case management services through a services coordinator or a personal agent.

(A) When the individual chooses case management services through a personal agent, the CDDP must send referral information to the appropriate support services brokerage within 5 days following the individual's decision.

(B) When the individual chooses case management services through a services coordinator, the CDDP must designate a services coordinator within 5 days following the individual's decision.

(C) When an individual is enrolled in a support services brokerage and moves from one CDDP geographic service area to another CDDP geographic service area, the new CDDP must enroll the individual in the Department's payment and reporting systems.

(2) CHANGE OF SERVICES COORDINATOR. The CDDP must keep the change of services coordinators to a minimum.

(a) If the CDDP changes services coordinator assignments, the CDDP must notify the individual, the individual's legal representative, and all current service providers within 10 working days of the change. The notification must be in writing and include the name, telephone number, and address of the new services coordinator.

(b) Effective July 1, 2013, the individual receiving services or the individual's legal representative may request a new services coordinator within the same CDDP or request case management services from a support services brokerage. The CDDP must develop standards and procedures for acting upon requests for change of services coordinators or when referring case management services to a brokerage. If another services coordinator is assigned by the CDDP, as the result of a request by the individual or the individual's legal representative, the CDDP must notify the individual, the individual's legal representative, and all current service providers within 10 working days of the change. The notification must be in writing and include the name, telephone number, and address of the new services coordinator.

(c) Effective July 1, 2013, if an individual or an individual's legal representative requests case management services through a support services brokerage, the CDDP must refer the individual or the individual's legal representative to the brokerage within 10 working days of the request.

(3) TERMINATION OF CASE MANAGEMENT SERVICES.

(a) A services coordinator retains responsibility for providing case management services to the individual until the responsibility is terminated in accordance with this rule, until another services coordinator is designated, or until the individual is enrolled in support services. The CDDP must terminate case management services when any of the following occur:

(A) The individual or the individual's legal representative delivers a signed written request that case management services be terminated or such a request by telephone is documented in the individual's file. An individual or an individual's legal representative may refuse contact by a services coordinator, as well as the involvement of a services coordinator at the ISP meeting, except if the services are mandatory as described in section (5) of this rule.

(B) The individual dies.

(C) The individual is determined to be ineligible for developmental disability services in accordance with OAR 411-320-0080.

(D) The individual moves out of state or to another county in Oregon. If an individual moves to another county, case management services must be referred and transferred to the new county, unless an individual requests otherwise and both the referring CDDP and the CDDP in the new county mutually agree. In the case of a child moving into a foster home or 24-hour residential home, the county of parental residency or court jurisdiction must retain case management responsibility.

(E) An individual cannot be located after repeated attempts by letter and telephone.

(b) If an individual is determined ineligible or cannot be located, the CDDP must issue a written notification of intent to terminate services in 30 days as well as notification of the individual's right to a hearing.

(4) TERMINATION FROM DEPARTMENT PAYMENT AND REPORTING SYSTEMS.

(a) The CDDP must terminate individuals in the Department payment and reporting systems when:

(A) The individual or the individual's legal representative delivers a signed written request to the support services brokerage requesting brokerage services be terminated. Individuals who decline support services but wish to continue receiving developmental disability services through the CDDP are terminated from the support services brokerage but are not terminated from developmental disability services;

(B) The individual dies;

(C) The individual is determined to be ineligible for developmental disability services in accordance with OAR 411-320-0080;

(D) The individual moves out of state or to another county in Oregon. If an individual moves to another county, developmental disability services must be referred and transferred to the new county, unless an individual requests otherwise and both the referring CDDP and the CDDP in the new county mutually agree; or

(E) Notification from the support services brokerage that an individual cannot be located after repeated attempts by letter and telephone.

(b) A CDDP retains responsibility for maintaining enrollment in the Department's payment and reporting systems for individuals enrolled in support services until the responsibility is terminated as described in this section of this rule.

(5) MANDATORY SERVICES. An individual in developmental disability services must accept the following services:

(a) Case management or support services;

(b) Abuse investigations;

(c) Services coordinator presence, when applicable, at Department-funded program entry, exit, or transfer meetings, or transition planning meetings required for entry or exit to adult services, including support services and in-home comprehensive supports for adults;

(d) Monitoring of service provider programs, when applicable; and

(e) Services coordinator access to individual files.

Stat. Auth.: ORS 409.050, 410.070, 430.640

Stats. Implemented: ORS 427.005, 427.007, 430.610 - 430.695

Hist.: SPD 24-2003, f. 12-29-03, cert. ef. 1-1-04; SPD 28-2004, f. & cert. ef. 8-3-04; SPD 16-2005(Temp), f. & cert. ef. 11-23-05 thru 5-22-06; SPD 5-2006, f. 1-25-06, cert. ef. 2-1-06; SPD 9-2009, f. & cert. ef. 7-13-09; SPD 22-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-320-0110

Entry and Exit Requirements

(1) ADMISSION TO A DEPARTMENT-FUNDED DEVELOPMENTAL DISABILITY PROGRAM.

(a) Department staff must authorize entry into children's residential services, children's proctor care, children's intensive in-home supports, and state operated community programs. The services coordinator must make referrals for admission and participate in all entry meetings for these programs.

(b) Admissions to all other Department-funded programs for individuals must be coordinated and authorized by the services coordinator in accordance with these rules.

(2) WRITTEN INFORMATION REQUIRED. The services coordinator, or the services coordinator's designee, must provide available and sufficient written information to service providers including information that is current and necessary to meet the individual's support needs in comprehensive services prior to admission.

(a) This written information must be provided in a timely manner and include:

(A) A copy of the individual's eligibility determination decision;

(B) A statement indicating the individual's safety skills including the ability to evacuate from a building when warned by a signal device and the ability to adjust water temperature for bathing and washing;

(C) A brief written history of any behavioral challenges including supervision and support needs;

(D) A medical history and information on health care supports that includes, where available:

(i) The results of a physical exam (if any) made within 90 days prior to the entry;

(ii) Results of any dental evaluation;

(iii) A record of immunizations;

(iv) A record of known communicable diseases and allergies; and

(v) A record of major illnesses and hospitalizations.

(E) A written record of any current or recommended medications, treatments, diets, and aids to physical functioning;

(F) A copy of the most current functional needs assessment. If the individual's needs have changed over time, the previous functional needs assessments must also be provided.

(G) If applicable, copies of protocols, the risk tracking record, and any support documentation;

(H) Copies of documents relating to guardianship, conservatorship, health care representative, power of attorney, court orders, probation and parole information, or any other legal restrictions on the rights of the individual, when applicable;

(I) Written documentation why preferences or choices of the individual cannot be honored at that time;

(J) Written documentation that the individual is participating in out-of-residence activities including school enrollment for individuals under the age of 21; and

(K) A copy of the most recent functional needs behavior assessment, Behavior Support Plan, ISP, and IEP, if applicable.

(b) If the individual is being admitted from the individual's family home and entry information is not available due to a crisis, the services coordinator must ensure that the service provider assesses the individual upon entry for issues of immediate health or safety and the services coordinator must document a plan to secure the information listed in subsection (a) of this section no later than 30 days after admission. The documentation must include a written description as to why the information is not available. A copy of the information and plan must be given to the service provider at the time of entry.

(c) If the individual is being admitted from comprehensive services, the information listed in subsection (a) of this section must be made available prior to the admission.

(3) ENTRY MEETING. Prior to an individual's date of entry into a Department-funded comprehensive service, the ISP team must meet to review referral material in order to determine appropriateness of placement. The ISP team participants are determined according to OAR 411-320-0120. The findings of the entry meeting must be recorded in the individual's file and distributed to the ISP team members. The documentation of the entry meeting must include at a minimum:

(a) The name of the individual proposed for services;

(b) The date of the entry meeting and the date determined to be the date of entry;

(c) The names and roles of the participants at the entry meeting;

(d) Documentation of the pre-entry information required by section (2)(a) of this rule;

(e) Documentation of the decision to serve or not serve the individual requesting service including the reason for the determination to not serve the individual; and

(f) If the decision was made to serve the individual, a written transition plan for no longer than 60 days that includes all medical, behavior, and safety supports needed by the individual;

(4) CRISIS DIVERSION SERVICES. For a period not to exceed 30 days, section (2)(a) of this rule does not apply if an individual is temporarily admitted to a program for crisis diversion services.

(5) EXIT AND TRANSFERS FROM DEPARTMENT-FUNDED PROGRAMS.

(a) All transfers or exits from Department-funded developmental disability services must be authorized by the CDDP.

(b) All transfers or exits from Department direct-contracted service for children's 24-hour residential and state-operated community programs must be authorized by Department staff.

(c) Prior to an individual's exit or transfer date, the ISP team must meet to review the exit or transfer and to plan and coordinate any services necessary during or following the exit or transfer. The ISP team participants are determined according to OAR 411-320-0120.

(6) EXIT STAFFING. The exit plan must be distributed to all ISP team members. The exit plan must include:

(a) The name of the individual considered for exit;

(b) The date of the exit meeting;

(c) Documentation of the participants included in the exit meeting;

(d) Documentation of the circumstances leading to the proposed exit;

(e) Documentation of the discussion of the strategies to prevent the individual's exit from service, unless the individual or the individual's legal representative is requesting the exit;

(f) Documentation of the decision regarding the individual's exit including verification of the voluntary decision to exit or a copy of the notice of involuntary transfer or exit; and

(g) The written plan for services for the individual after exit.

(7) TRANSFER MEETING. A transfer meeting of the ISP team must precede any decision to transfer an individual. Findings of such a transfer meeting must be recorded in the individual's file and include, at a minimum:

(a) The name of the individual considered for transfer;

(b) The date of the transfer meeting;

(c) Documentation of the participants included in the transfer meeting;

(d) Documentation of the circumstances leading to the proposed transfer;

(e) Documentation of the alternatives considered instead of transfer;

(f) Documentation of the reasons any preferences of the individual or the individual's legal representative or family members may not be honored;

(g) Documentation of the decision regarding transfer including verification of the voluntary decision to transfer or exit, or a copy of the notice of involuntary transfer or exit; and

(h) The written plan for services for the individual after transfer.

(8) ENTRY TO SUPPORT SERVICES.

(a) Referrals of eligible individuals to a support services brokerage must be made in accordance with OAR 411-340-0110. Referrals must be made using the Department mandated application and referral form in accordance with Department guidelines.

(b) The CDDP of an individual's county of origin may find the individual eligible for services from a support services brokerage when:

(A) The individual is an Oregon resident who has been determined eligible for developmental disability services by the CDDP; AND

(B) The individual is an adult living in the individual's own home or family home; AND

(C) At the time of initial entry to the brokerage, the individual is not enrolled in comprehensive services; AND

(D) At the time of initial entry to the support services brokerage, the individual is not receiving crisis diversion services from the Department because the individual does not meet one or more of the crisis risk factors listed in OAR 411-320-0160; AND

(E) The individual, or the individual's legal representative, has chosen to use a support service brokerage for assistance with design and management of personal supports;

(c) The individual must be referred within 90 days of:

(A) Being determined eligible for developmental disability services;

(B) Being determined eligible for entry to the Support Services Waiver;

(C) The individual's 18th birth date:

(D) Requesting support services; and

(E) Selecting an available support services brokerage within the CDDP's geographic service area.

(d) The individual must complete entry within 90 days of referral to the support services brokerage.

(e) The services coordinator must communicate with the support services brokerage staff and provide all relevant information upon request and as needed to assist support services brokerage staff in developing an ISP that best meets the individual's support needs including:

(A) A current application or referral on the Department mandated application or referral form;

(B) A completed level of care assessment form;

(C) A copy of the eligibility statement for developmental disability services;

(D) Copies of financial eligibility information;

(E) Copies of any legal documents such as guardianship papers, conservatorship, civil commitment status, probation and parole, etc;

(F) Copies of relevant progress notes; and

(G) A copy of any current plans.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 409.050, 410.070, 430.640

Stats. Implemented: ORS 427.005, 427.007, 430.610 - 430.695

Hist.: SPD 24-2003, f. 12-29-03, cert. ef. 1-1-04; SPD 28-2004, f. & cert. ef. 8-3-04; SPD 16-2005(Temp), f. & cert. ef. 11-23-05 thru 5-22-06; SPD 5-2006, f. 1-25-06, cert. ef. 2-1-06; SPD 9-2009, f. & cert. ef. 7-13-09; SPD 18-2011(Temp), f. & cert. ef. 7-1-11 thru 12-28-11; SPD 27-2011, f. & cert. ef. 12-28-11; SPD 22-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-320-0120
Service Planning

(1) PRINCIPLES FOR PLANNING. These rules prescribe standards for the development and implementation of plans for individuals. As such, plans for individuals must be developed using a person centered process and in a manner that address issues of independence, integration and productivity, enhance the quality of life of the individual with intellectual or developmental disabilities, and consistent with the following principles:

(a) Personal Control and Family Participation. While the service system reflects the value of family member participation in the planning process, adult individuals have the right to make informed choices about the level of participation by family members. It is the intent of this rule to fully support the provision of education about personal control and decision-making to individuals who are receiving services.

(b) Choice and Preferences. The planning process is critical in determining the individual's and the family's preferences for services and supports. The preferences of the individual and family must serve to guide the ISP team. The individual's active participation and input must be facilitated throughout the planning process.

(c) Barriers. The planning process is designed to identify the types of services and supports necessary to achieve the individual's and family's preferences, identify the barriers to providing those preferred services, and develop strategies for reducing the barriers.

(d) Health and Safety. The planning process must also identify strategies to assist the individual in the exercise of the individual's rights. This may create tensions between the freedom of choice and interventions necessary to protect the individual from harm. The ISP team must carefully nurture the individual's exercise of rights while being equally sensitive to protecting the individual's health and safety.

(e) Children in Alternate Living Situations. When planning for children in 24-hour residential or foster care services, maintaining family connections is an important consideration. The following must apply:

(A) Unless contraindicated there must be a goal for family reunification;

(B) The number of moves or transfers must be kept to a minimum; and

(C) If the placement is distant from the family, the services coordinator must continue to seek a placement that would bring the child closer to the family.

(2) RESPONSIBILITY FOR THE FUNCTIONAL NEEDS ASSESSMENT. Effective July 1, 2013, the services coordinator must complete a functional needs assessment at least annually. The FNAT must be completed:

(a) Within 30 days following the assignment of a services coordinator,

(b) Within 30 days prior to the authorization of a plan renewal; and

(c) Not more than 45 days from the date an FNAT is requested by the individual or individual's legal representative.

(3) RESPONSIBILITY FOR ANNUAL ISP OR ANNUAL PLAN. Individuals enrolled in waivered or state plan services must have an annual ISP or Annual Plan.

(a) The services coordinator must develop with the individual, the individual's legal representative, and other invited ISP team members, an ISP within 90 days of the individual's entry into comprehensive services and at least annually thereafter.

(b) Upon request of a new functional needs assessment, the services coordinator must authorize a new ISP within 30 days of the FNAT, developed with the individual, the individual's legal representative, and other invited ISP team members.

(c) The CDDP must provide a written copy of the most current ISP to the individual, the individual's legal representative, and others as identified by the individual. For an initial or annual ISP that is authorized after July 1, 2013, the ISP must address all the support needs identified on the FNAT. The ISP or attached documents must include:

(A) The individual's name;

(B) A description of the supports required, including the reason the support is necessary. For an initial or annual ISP that is authorized after July 1, 2013 the description must be consistent with the FNAT;

(C) Projected dates of when specific supports are to begin and end;

(D) A list of personal, community, and public resources that are available to the individual and how they shall be applied to provide the required supports. Sources of support may include waivered or state plan services, state general funds, or natural supports.

(d) Plans must be developed, implemented, and authorized as follows:

(A) FOSTER CARE, 24-HOUR RESIDENTIAL SERVICES, EMPLOYMENT OR ALTERNATIVES TO EMPLOYMENT SERVICES.

(i) For individuals in foster care, 24-hour residential services, and related employment or alternatives to employment services, a services coordinator, or the services coordinator's qualified designee, must attend and assure that an annual ISP meeting is held. The services coordinator, or the services coordinator's qualified designee, must participate in the development of the ISP for individuals enrolled in foster care, 24-hour residential services, and related employment or alternatives to employment services.

(ii) ISP's for children in Department direct contracted children's 24 hour residential services must be coordinated by Department staff.

(iii) The services coordinator must ensure that the ISP for individuals in foster care or 24-hour residential services is developed and updated in accordance with state guidelines. The services coordinator must track the plan timelines and coordinate the resolution of complaints and conflicts arising from ISP discussions.

(iv) At a minimum, the ISP team must include the individual, the individual's legal representative, the services coordinator, and representatives from the 24-hour residential program, a representative from the employment or alternatives to employment program (if any) , and any treatment professional requested by the individual or the ISP team on behalf of the individual.

(B) SUPPORTED LIVING SERVICES. The services coordinator for an adult in supported living services and any associated employment or alternative to employment program must ensure the development of an annual ISP. The services coordinator must facilitate and develop an ISP with the individual and others invited by the individual in conformance with the ISP content described in sections (3) and (4) of this rule.

(C) FAMILY SUPPORT. The services coordinator must coordinate with the individual's family or the individual's legal representative in the development of the Annual Plan for a child receiving family support services. The Annual Plan must be in accordance with OAR 411-305-0080.

(D) COMPREHENSIVE IN-HOME SUPPORTS. The services coordinator must coordinate with the individual, the individual's family, or the individual's legal representative, in the development of the annual In-Home Support Plan for the individual enrolled in comprehensive in-home supports in accordance with OAR 411-330-0050.

(E) LONG-TERM SUPPORTS FOR CHILDREN. The services coordinator must coordinate with the individual, the individual's family, or the individual's legal representative, in the development of the child's Annual Support Plan in accordance with OAR chapter 411, division 308.

(F) ANNUAL PLAN. For individuals not enrolled or not yet enrolled in any other Department-funded developmental disability service, the services coordinator must ensure the completion of an Annual Plan. The Annual Plan must be completed within 60 days of enrollment into case management services, and annually thereafter if not enrolled in any other Department-funded developmental disability service.

(i) For an adult, a written Annual Plan must be documented in the individual's service record as an Annual Plan or as a comprehensive progress note and consist of:

(I) A review of the individual's current living situation;

(II) A review of any personal health, safety, or behavioral concerns;

(III) A summary of support needs of the individual; and

(IV) Actions to be taken by the services coordinator and others.

(ii) For a child, the services coordinator must ensure the completion of a child's Annual Plan in accordance with OAR 411-305-0080.

(4) PLAN CONTENT. The services coordinator must ensure that individual plans conform to the requirements of this rule.

(a) The services coordinator must ensure that a plan for an individual in Department-funded comprehensive services is developed and documents a person centered process that identifies what is important to and for an individual, and also identifies the supports necessary to address issues of health, behavior, safety, and financial supports. There must be documentation of an action plan or discussion record resulting from the ISP team's discussion addressing issues of conflict between personal preferences and issues of health and safety.

(b) The services coordinator must ensure that a plan developed for a child receiving Department-funded family support services conforms to the requirements of OAR chapter 411, division 305.

(c) The services coordinator must ensure that an In-Home Support Plan for adults conforms to the requirements described in OAR 411-330-0050.

(d) The services coordinator must ensure that a child's Annual Support Plan for long-term support conforms to the requirements in OAR 411-308-0080.

(5) PLAN FORMATS. The ISP, Annual Plan, or In-Home Support Plan developed at the annual or update meeting must be conducted in a manner specified by and on forms required by the Department. In the absence of a Department-mandated form, the CDDP with the affected service providers may develop an ISP format that conforms to the licensing or certification service provider rule and provides for an integrated plan across the funded developmental disability service settings.

(6) PLAN UPDATES. Plans for individuals must be kept current. The services coordinator or the Department's Residential Services Coordinator for children in Department- directed contracted 24-hour residential services must ensure that a current plan for individuals enrolled in comprehensive services, long-term supports for children, or in family support services is authorized and maintained.

(a) The plan must be kept in the individual's service record.

(b) Plan updates must occur as required by this rule and any rules governing the operation of the service.

(c) When there is a significant change the plan must be updated.

(7) TEAM PROCESS IN SERVICE AND SUPPORT PLANNING. Except in in-home supports or long-term supports for children, the following applies to ISPs developed for individuals in comprehensive services:

(a) ISPs must be developed by the ISP team that includes the services coordinator, the individual and the individual's legal representative, and others invited or agreed upon by the individual. The ISP team assigns responsibility for obtaining or providing services to meet the individual's identified needs.

(A) Membership on ISP teams must at a minimum conform to this rule and any relevant service provider rules.

(B) Unless refused by the adult individual, family participation must be encouraged.

(C) The individual may also suggest additional participants, friends, or significant others.

(D) The individual may raise an objection to a particular person. When an individual raises objections to a person, the ISP team must respect the individual's request. In order to assure adequate planning, provider representatives are necessary participants on the team.

(b) Plans developed by an ISP team must respect and honor individual choice in the development of a meaningful plan. Consensus amongst team members is prioritized.

(A) No one member of the ISP team has the authority to make decisions for the team unless so authorized by the team process.

(B) In circumstances where an individual is unable to express their opinion or choice using words, behaviors, or other means of communication, and does not have a legal or designated representative, the ISP team is empowered to make a decision.

(C) When consensus cannot be reached, majority agreement is used. For purposes of reaching a majority agreement, service providers, families, community developmental disability programs, advocacy agencies, or individuals and the individual's representative are considered as one member of the ISP team.

(D) Any ISP team member's objections to ISP decisions must be documented in the ISP.

(E) Using a person centered planning process, and with agreement by the individual and the individual's legal representative, the plan is authorized by the services coordinator.

(F) The individual or the individual's legal representative retains the right to consent to treatment and training or to note any specific areas of the plan that they object to and wish to file a complaint.

(G) The ISP team members must keep the team informed whenever there are significant needs or changes, or there is a crisis or potential for a crisis. The services coordinator must be notified in all such instances.

Stat. Auth.: ORS 409.050, 410.070, 430.640

Stats. Implemented: ORS 427.005, 427.007, 430.610 - 430.695

Hist.: SPD 24-2003, f. 12-29-03, cert. ef. 1-1-04; SPD 28-2004, f. & cert. ef. 8-3-04; SPD 16-2005(Temp), f. & cert. ef. 11-23-05 thru 5-22-06; SPD 5-2006, f. 1-25-06, cert. ef. 2-1-06; SPD 9-2009, f. & cert. ef. 7-13-09; SPD 22-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-320-0130

Site Visits and Monitoring of Services

(1) SITE VISITS TO DEPARTMENT LICENSED OR CERTIFIED SERVICE PROVIDER SITES. The CDDP must ensure that site visits are conducted at each child or adult foster home, each 24-hour residential program site, and each employment provider licensed or certified by the Department to serve individuals with intellectual or developmental disabilities.

(a) The CDDP must establish a quarterly schedule for site visits to each child or adult foster home and each 24-hour residential program.

(b) The CDDP must establish an annual schedule for visits with individuals receiving supported living services. If an individual opposes a visit to their home, a mutually agreed upon location for the visit must be arranged.

(c) The CDDP must establish an annual schedule for visits to employment or alternatives to employment sites. If a visit to an integrated employment site disrupts the work occurring, a mutually agreed upon location for the visit must be arranged.

(d) Site visits may be increased for the following reasons including but not limited to:

(A) Increased certified and licensed capacity;

(B) New individuals being served;

(C) Newly licensed or certified provider;

(D) An abuse investigation;

(E) A serious event occurring;

(F) A change in the management or staff of the certified or licensed provider;

(G) An ISP team request;

(H) Individuals who are also receiving crisis services; or

(I) Significant change in an individual's functioning who receives services at the site.

(e) The CDDP must develop a procedure for the conduct of the visits to these sites.

(f) The CDDP must document site visits and provide information concerning such visits to the Department upon request.

(g) If there are no Department-funded individuals at the site, a visit by the CDDP is not required.

(h) When the service provider is a Department-contracted and licensed 24-hour residential program for children or is a proctor agency and the Department's Children's Residential Services Coordinator is assigned to monitor services, the Department's Children's Residential Services Coordinator and the CDDP must coordinate who visits the home. If the visit is made by Department staff, Department staff must provide the results of the monitoring visit to the local services coordinator.

(i) The Department may conduct monitoring visits on a more frequent basis than described in this section based on program needs.

(2) MONITORING OF SERVICES: The services coordinator must conduct monitoring activities using the framework described in this section.

(a) For individuals residing in 24-hour residential programs, supported living, foster care, or employment or alternatives to employment services, ongoing reviews of the individual's ISP determine whether the actions identified by the ISP team are being implemented by service providers and others. The review of an ISP must include an assessment of the following:

(A) Are services being provided as described in the plan document and do they result in the achievement of the identified action plans;

(B) Are the personal, civil, and legal rights of the individual protected in accordance with this rule;

(C) Are the personal desires of the individual, the individual's legal representative, or family addressed;

(D) Do the services provided for in the plan continue to meet what is important to and for the individual; and

(E) Do identified goals remain relevant and are the goals supported and being met?

(b) For individuals residing in 24-hour residential programs, supported living, foster care, or receiving employment or alternatives to employment, the monitoring of services may be combined with the site visits described in section (1) of this rule. In addition:

(A) During a one year period, the services coordinator must review, at least once, services specific to health, safety, and behavior, using questions established by the Department.

(B) A semi-annual review of the process by which an individual accesses and utilizes funds, and determines whether financial records, bank statements, and personal spending funds are accurate must occur, using questions established by the Department.

(i) For individuals receiving 24-hour residential services, the financial review standards are described in OAR 411-325-0380.

(ii) For individuals receiving adult foster care services, the financial review standards are described in OAR 411-360-0170.

(iii) Any misuse of funds must be reported to the CDDP and the Department. The Department determines whether a referral to the Medicaid Fraud Control Unit is warranted.

(C) The services coordinator must monitor reports of serious and unusual incidents.

(c) For individuals receiving employment or alternatives to employment services, the services coordinator must assess the individual's progress toward a path to employment.

(d) The frequency of service monitoring must be determined by the needs of the individual. Events identified in section (1)(d) of this rule provide indicators that may potentially increase the need for service monitoring.

(e) For individuals receiving only case management services and who are not enrolled in any other funded developmental disability service, the services coordinator must make contact with the individual at least once annually.

(A) Whenever possible, annual contact must be made in person. If annual contact is not made in person, the progress note must document how contact was achieved.

(B) The services coordinator must document annual contact in an Annual Plan as described in OAR 411-320-0120.

(C) If the individual has any identified high-risk medical issue including but not limited to risk of death due to aspiration, seizures, constipation, dehydration, diabetes, or significant behavioral issues, the services coordinator must maintain contact in accordance with planned actions as described in the individual's Annual Plan.

(D) Any follow-up activities must be documented in the progress notes.

(3) MONITORING FOLLOW-UP. The services coordinator and the CDDP are responsible for ensuring the appropriate follow-up to monitoring of services, except in the instance of children in a Department direct contract 24-hour residential service when the Department may conduct the follow-up.

(a) If the services coordinator determines that comprehensive services are not being delivered as agreed in the ISP, or that an individual's service needs have changed since the last review, the services coordinator must initiate action to update the ISP.

(b) If there are concerns regarding the service provider's ability to provide services, the CDDP, in consultation with the services coordinator, must determine the need for technical assistance or other follow-up activities. This may include coordination or provision of technical assistance, referral to the CDDP manager for consultation or corrective action, requesting assistance from the Department for licensing or other administrative support, or meeting with the service provider executive director or board of directors. In addition to conducting abuse or other investigations as necessary, the CDDP must notify the Department when:

(A) A service provider demonstrates substantial failure to comply with any applicable licensing, certification, or endorsement rules for Department-funded programs;

(B) The CDDP finds a serious and current threat endangering the health, safety, or welfare of individuals in a program for which an immediate action by the Department is required; or

(C) Any individual receiving Department-funded developmental disability services dies. Notification must be made to the Director or his or her designee within one working day of the death. Entry must be made into the Serious Event Review System according to Department guidelines.

Stat. Auth.: ORS 409.050, 410.070, 430.640

Stats. Implemented: ORS 427.005, 427.007, 430.610 - 430.695

Hist.: SPD 24-2003, f. 12-29-03, cert. ef. 1-1-04; SPD 28-2004, f. & cert. ef. 8-3-04; SPD 16-2005(Temp), f. & cert. ef. 11-23-05 thru 5-22-06; SPD 5-2006, f. 1-25-06, cert. ef. 2-1-06; SPD 9-2009, f. & cert. ef. 7-13-09; SPD 27-2010(Temp), f. & cert. ef. 12-1-10 thru 5-30-11; SPD 11-2011, f. & cert. ef. 6-2-11; SPD 22-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

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Rule Caption: 24-Hour Residential Services for Children and Adults with Intellectual or Developmental Disabilities

Adm. Order No.: SPD 23-2013(Temp)

Filed with Sec. of State: 7-1-2013

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Notice Publication Date:

Rules Amended: 411-325-0020, 411-325-0390, 411-325-0400, 411-325-0440

Subject: The Department of Human Services (Department) is immediately amending the 24-hour residential services rules for children and adults with intellectual or developmental disabilities in OAR chapter 411, division 325 to:

Specify the eligibility requirements for home and community-based waivered services to reflect changes made as a result of the Department's Community First Choice State Plan; and

Clarify the notice requirements and hearing rights for involuntary transfers and exits to comply with the Code of Federal Regulations and implement corrective actions required as a result of the Centers for Medicare and Medicaid Services' (CMS) review of the Department's Home and Community-Based Services Waiver.

Rules Coordinator: Christina Hartman—(503) 945-6398

411-325-0020
Definitions

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 325:

(1) "24-Hour Residential Program" means a comprehensive residential home licensed by the Department under ORS 443.410 to provide residential care and training to individuals with intellectual or developmental disabilities.

(2) "Abuse" means:

(a) For a child with or without an intellectual or developmental disability, abuse as defined in ORS 419B.005.(b) For a child with an intellectual or developmental disability receiving 24-hour residential services and for an adult with an intellectual or developmental disability, abuse as defined in OAR 407-045-0260.

(3) "Abuse Investigation and Protective Services" means reporting and investigation activities as required by OAR 407-045-0300 and any subsequent services or supports necessary to prevent further abuse as required in OAR 407-045-0310.

(4) "Administration of Medication" means the act of placing a medication in or on an individual's body by a staff member who is responsible for the individual's care.

(5) "Adult" means an individual 18 years or older with an intellectual or developmental disability.

(6) "Advocate" means a person other than paid staff who has been selected by an individual or by the individual's legal representative to help the individual understand and make choices in matters relating to identification of needs and choices of services, especially when rights are at risk or have been violated.

(7) "Aid to Physical Functioning" means any special equipment prescribed for an individual by a physician, therapist, or dietician that maintains or enhances the individual's physical functioning.

(8) "Appeal" means the process under ORS chapter 183 that a service provider may use to petition conditions or the suspension, denial, or revocation of an application, certificate, endorsement, or license.

(9) "Applicant" means a person, agency, corporation, or governmental unit, who applies for a license to operate a residential home providing 24-hour comprehensive residential services.

(10) "Assessment" means the evaluation of an individual's needs.

(11) "Baseline Level of Behavior" means the frequency, duration, or intensity of a behavior, objectively measured, described, and documented prior to the implementation of an initial or revised Behavior Support Plan. This baseline measure serves as the reference point by which the ongoing efficacy of an Individual Support Plan (ISP) is to be assessed. A baseline level of behavior is reviewed and reestablished at minimum yearly, at the time of an ISP team meeting.

(12) "Behavior Data Collection System" means the methodology specified within a Behavior Support Plan that directs the process for recording observations, interventions, and other support provision information critical to the analysis of the efficacy of the Behavior Support Plan.

(13) "Behavior Data Summary" means the document composed by a service provider to summarize episodes of physical intervention. The behavior data summary serves as a substitution for the requirement of an incident report for each episode of physical intervention.

(14) "Board of Directors" means the group of persons formed to set policy and give directions to a service provider that provides 24-hour residential services. A board of directors includes local advisory boards used by multi-state organizations.

(15) "Case Management" means an organized service to assist individuals to select, obtain, and utilize resources and services.

(16) "CDDP" means "Community Developmental Disability Program" as defined in this rule.

(17) "Certificate" means the document issued by the Department to a service provider that certifies the service provider is eligible under the rules in OAR chapter 411, division 323 to receive state funds for the provision of endorsed 24-hour residential services.

(18) "Chemical Restraint" means the use of a psychotropic drug or other drugs for punishment or to modify behavior in place of a meaningful behavior or treatment plan.

(19) "Child" means an individual who is less than 18 years of age that has a provisional determination of an intellectual or developmental disability.

(20) "Choice" means an individual's expression of preference, opportunity for, and active role in decision-making related to services received and from whom, including but not limited to case management, service providers, and service settings. Personal outcomes, goals, and activities are supported in the context of balancing an individual's rights, risks, and personal choices. Individuals are supported in opportunities to make changes when so expressed. Choice may be communicated verbally, through sign language, or by other communication methods.

(21) "Community Developmental Disability Program (CDDP)" means the entity that is responsible for the planning and delivery of services for individuals with intellectual or developmental disabilities according to OAR chapter 411, division 320. A CDDP operates in a specific geographic service area of the state under a contract with the Department, local mental health authority, or other entity as contracted by the Department.

(22) "Community First Choice State Plan" means Oregon's state plan amendment authorized under section 1915(k) of the Social Security Act.

(23) "Competency Based Training Plan" means the written description of a service provider's process for providing training to newly hired staff. At a minimum, the Competency Based Training Plan:

(a) Addresses health, safety, rights, values and personal regard, and the service provider's mission; and

(b) Describes competencies, training methods, timelines, how competencies of staff are determined and documented including steps for remediation, and when a competency may be waived by a service provider to accommodate a staff member's specific circumstances.

(24) "Complaint Investigation" means the investigation of any complaint that has been made to a proper authority that is not covered by an abuse investigation.

(25) "Condition" means a provision attached to a new or existing certificate, endorsement, or license that limits or restricts the scope of the certificate, endorsement, or license or imposes additional requirements on the service provider.

(26) "Crisis" means:

(a) A situation as determined by a qualified services coordinator that may result in civil court commitment under ORS 427.215 to 427.306 and for which no appropriate alternative resources are available; or

(b) Risk factors described in OAR 411-320-0160(2) are present for which no appropriate alternative resources are available.

(27) "Denial" means the refusal of the Department to issue a certificate, endorsement, or license to operate a 24-hour residential home for individuals with intellectual or developmental disabilities because the Department has determined that the service provider or the home is not in compliance with these rules or the rules in OAR chapter 411, division 323.

(28) "Department" means the Department of Human Services (DHS). The term "Department" is synonymous with "Seniors and People with Disabilities Division (SPD)".

(29) "Developmental Disability" means a neurological condition that originates in the developmental years, that is likely to continue, and significantly impacts adaptive behavior as diagnosed and measured by a qualified professional as described in OAR 411-320-0080.

(30) "Direct Nursing Service" means the provision of individual-specific advice, plans, or interventions by a nurse at a home based on the nursing process as outlined by the Oregon State Board of Nursing. Direct nursing service differs from administrative nursing services. Administrative nursing services include non-individual-specific services, such as quality assurance reviews, authoring health related agency policies and procedures, or providing general training for staff.

(31) "Director" means the Director of the Department's Office of Developmental Disability Services, or the Director's designee.

(32) "Domestic Animals" mean the animals domesticated so as to live and breed in a tame condition. Examples of domestic animals include but are not limited to dogs, cats, and domesticated farm stock.

(33) "Educational Surrogate" means the person who acts in place of a parent in safeguarding a child's rights in the special education decision-making process:

(a) When the parent cannot be identified or located after reasonable efforts;

(b) When there is reasonable cause to believe that the child has a disability and is a ward of the state; or

(c) At the request of the parent or adult student.

(34) "Endorsement" means the authorization to provide 24-hour residential services issued by the Department to a certified service provider that has met the qualification criteria outlined in these rules and the rules in OAR chapter 411, division 323.

(35) "Entry" means admission to a Department-funded developmental disability service in a licensed 24-hour residential home.

(36) "Executive Director" means the person designated by a board of directors or corporate owner that is responsible for the administration of 24-hour residential services.

(37) "Exit" means termination or discontinuance of:

(a) Services from a service provider; or

(b) Department-funded developmental disability services..

(38) "Founded Reports" means the Department's or Law Enforcement Authority's (LEA) determination, based on the evidence, that there is reasonable cause to believe that conduct in violation of the child abuse statutes or rules has occurred and such conduct is attributable to a person alleged to have engaged in the conduct.

(39) "Functional Needs Assessment (FNAT)" means an assessment that documents the level of need, accommodates an individual's participation in service planning, and includes:

(a) Completing a comprehensive and holistic assessment;

(b) Surveying physical, mental, and social functioning; and

(c) Identifying risk factors, choices and preferences, and service needs.

(40) "Guardian" means a parent for an individual less than 18 years of age or a person or agency appointed and authorized by the courts to make decisions about services for an individual.

(41) "Health Care Provider" means the person or health care facility licensed, certified, or otherwise authorized or permitted by Oregon law to administer health care in the ordinary course of business or practice of a profession.

(42) "Health Care Representative" means:

(a) A health care representative as defined in ORS 127.505; or

(b) A person who has authority to make health care decisions for an individual under the provisions of OAR chapter 411, division 365.

(43) "Home and Community-Based Waivered Services" mean the services approved by the Centers for Medicare and Medicaid Services in accordance with Section 1915(c) and 1115 of the Social Security Act.

(44) "Incident Report" means the written report of any injury, accident, acts of physical aggression, or unusual incident involving an individual.

(45) "Independence" means the extent to which individuals exert control and choice over their own lives.

(46) "Individual" means an adult or a child with an intellectual or developmental disability applying for or determined eligible for developmental disability services.

(47) "Individualized Education Plan (IEP)" means the written plan of instructional goals and objectives developed in conference with an individual and the individual's legal representative, teacher, and a representative of the school district.

(48) "Individual Support Plan (ISP)" means the written details of the supports, activities, and resources required for an individual to achieve personal outcomes. Individual support needs are identified through a Functional Needs Assessment. The manner in which services are delivered, service providers, and the frequency of services are reflected in an ISP. The ISP is developed at minimum annually to reflect decisions and agreements made during a person-centered process of planning and information gathering. The ISP includes an individual's Plan of Care for Medicaid purposes and reflects whether services are purchased through a waiver, state plan, or provided through an individual's natural supports.

(49) "Individual Support Plan (ISP) Team" means a team composed of an individual receiving services and the individual's legal representative, services coordinator or personal agent, and others chosen by the individual. Others chosen by the individual may include service providers, family members, or other persons requested by the individual.

(50) "Integration" as defined in ORS 427.005 means:

(a) The use by individuals with intellectual or developmental disabilities of the same community resources used by and available to other persons;

(b) Participation by individuals with intellectual or developmental disabilities in the same community activities in which persons without an intellectual or developmental disability participate, together with regular contact with persons without an intellectual or developmental disability; and

(c) Individuals with intellectual or developmental disabilities reside in homes or home-like settings that are in proximity to community resources and foster contact with persons in the community.

(51) "Intellectual Disability" has the meaning set forth in OAR 411-320-0020 and described in OAR 411-320-0080.

(52) "Involuntary Transfer" means a service provider has made the decision to transfer an individual and the individual or the individual's legal representative has not given prior approval.

(53) "ISP" means "Individual Support Plan" as defined in this rule.

(54) "Legal Representative" means:

(a) For a child, the parent unless a court appoints another person or agency to act as guardian; and

(b) For an adult, an attorney at law who has been retained by or for an individual or a person or agency authorized by a court to make decisions about services for an individual.

(55) "Level of Care" means an assessment completed by a services coordinator has determined an individual meets institutional level of care. An individual meets institutional level of care for an intermediate care facility for individuals with intellectual or developmental disabilities if:

(a) The individual has a condition of an intellectual disability or a developmental disability as defined in OAR 411-320-0020 and meets the eligibility criteria for developmental disability services as described in OAR 411-320-0080; and

(b) The individual has a significant impairment in one or more areas of adaptive functioning. Areas of adaptive functioning include self direction, self care, home living, community use, social, communication, mobility, or health and safety.

(56) "Licensee" means the person or organization to whom a certificate, endorsement, and license is granted.

(57) "Majority Agreement" means that no one member of the Individual Support Plan team has the authority to make decisions for the team unless so authorized by the team process. A service provider, community developmental disability program, advocate, individual, and the individual's family are considered as one member of the ISP team for the purpose of reaching majority agreement.

(58) "Mandatory Reporter" means any public or private official as defined in OAR 407-045-0260 who:

(a) Is a staff or volunteer working with a child who, comes in contact with and has reasonable cause to believe a child with or without an intellectual or developmental disability has suffered abuse, or comes in contact with any person whom the official has reasonable cause to believe abused a child with or without an intellectual or developmental disability, regardless of whether or not the knowledge of the abuse was gained in the reporter's official capacity. Nothing contained in ORS 40.225 to 40.295 affects the duty to report imposed by this section, except that a psychiatrist, psychologist, clergy, attorney, or guardian ad litem appointed under ORS 419B.231 is not required to report if the communication is privileged under ORS 40.225 to 40.295.

(b) Is a staff or volunteer working with an adult who, while acting in an official capacity, comes in contact with and has reasonable cause to believe an adult with an intellectual or developmental disability has suffered abuse, or comes in contact with any person whom the official has reasonable cause to believe abused an adult with an intellectual or developmental disability. Nothing contained in ORS 40.225 to 40.295 affects the duty to report imposed by this section of this rule, except that a psychiatrist, psychologist, clergy, or attorney is not required to report if the communication is privileged under ORS 40.225 to 40.295.

(59) "Mechanical Restraint" means any mechanical device, material, object, or equipment that is attached or adjacent to an individual's body that the individual cannot easily remove or easily negotiate around, and that restricts freedom of movement or access to the individual's body.

(60) "Medicaid Agency Identification Number" means the numeric identifier assigned by the Department to a service provider following the service provider's enrollment as described in OAR chapter 411, division 370.

(61) "Medicaid Performing Provider Number" means the numeric identifier assigned to an entity or person by the Department, following enrollment to deliver Medicaid funded services as described in OAR chapter 411, division 370. The Medicaid Performing Provider Number is used by the rendering service provider for identification and billing purposes associated with service authorizations and payments.

(62) "Medication" means any drug, chemical, compound, suspension, or preparation in suitable form for use as a curative or remedial substance taken either internally or externally by any person.

(63) "Modified Diet" means the texture or consistency of food or drink is altered or limited. Examples include but are not limited to, no nuts or raw vegetables, thickened fluids, mechanical soft, finely chopped, pureed, or bread only soaked in milk.

(64) "Natural Supports" or "Natural Support System" means the resources available to an individual from the individual's relatives, friends, significant others, neighbors, roommates, and the community. Services provided by natural supports are resources that are not paid for by the Department.

(65) "Nurse" means a person who holds a current license from the Oregon Board of Nursing as a registered nurse or licensed practical nurse pursuant to ORS chapter 678.

(66) "Nursing Care Plan" means the plan of care developed by a registered nurse that describes the medical, nursing, psychosocial, and other needs of an individual and how those needs are met. The Nursing Care Plan includes the tasks that are taught or delegated to the service provider and staff.

(67) "OIS" means "Oregon Intervention System" as defined in this rule.

(68) "Oregon Core Competencies" means:

(a) The list of skills and knowledge required for newly hired staff in the areas of health, safety, rights, values and personal regard, and the service provider's mission; and

(b) The associated timelines in which newly hired staff must demonstrate the competencies.

(69) "Oregon Intervention System (OIS)" means the system of providing training to people who work with designated individuals to provide elements of positive behavior support and non-aversive behavior intervention. OIS uses principles of pro-active support and describes approved protective physical intervention techniques that are used to maintain health and safety.

(70) "OSIP-M" means Oregon Supplemental Income Program-Medical as defined in OAR 461-101-0010. OSIP-M is Oregon Medicaid insurance coverage for an individual who meets eligibility criteria as described in OAR chapter 461.

(71) "Person-Centered Planning" means:

(a) A process, either formal or informal, for gathering and organizing information that helps an individual:

(A) Determine and describe choices about personal goals, activities, and lifestyle preferences;

(B) Design strategies and networks of support to achieve goals and a preferred lifestyle using individual strengths, relationships, and resources; and

(C) Identify, use, and strengthen naturally occurring opportunities for support at home and in the community.

(b) The methods for gathering information vary, but all are consistent with individual needs and preferences.

(72) "Prescription Medication" means any medication that requires a physician's prescription before the medication may be obtained from a pharmacist.

(73) "Productivity" as defined in ORS 427.005 means:

(a) Engagement in income-producing work by an individual that is measured through improvements in income level, employment status, or job advancement; or

(b) Engagement by an individual in work contributing to a household or community.

(74) "Protection" and "Protective Services" means necessary actions taken as soon as possible to prevent subsequent abuse or exploitation of an individual, to prevent self-destructive acts, or to safeguard an individual's person, property, and funds.

(75) "Protective Physical Intervention (PPI)" means any manual physical holding of, or contact with, an individual that restricts the individual's freedom of movement. The term "protective physical intervention" is synonymous with "physical restraint".

(76) "Psychotropic Medication" means medication the prescribed intent of which is to affect or alter thought processes, mood, or behavior including but not limited to anti-psychotic, antidepressant, anxiolytic (anti-anxiety), and behavior medications. The classification of a medication depends upon its stated, intended effect when prescribed.

(77) "Respite" means intermittent services provided on a periodic basis, but not more than 14 consecutive days, for the relief of, or due to the temporary absence of, a person normally providing supports to an individual unable to care for him or herself.

(78) "Revocation" means the action taken by the Department to rescind a certificate, endorsement, or 24-hour home license after the Department has determined that the service provider is not in compliance with these rules or the rules in OAR chapter 411, division 323.

(79) "Self-Administration of Medication" means an individual manages and takes his or her own medication, identifies his or her own medication and the times and methods of administration, places the medication internally in or externally on his or her own body without staff assistance upon written order of a physician, and safely maintains the medication without supervision.

(80) "Service Provider" means a public or private community agency or organization that provides recognized developmental disability services and is certified and endorsed by the Department to provide these services under these rules and the rules in OAR chapter 411, division 323. The use of the terms "agency", "provider", "program", "applicant", or "licensee" are synonymous with "service provider."

(81) "Services" mean supportive services, including but not limited to supervision, protection, and assistance in bathing, dressing, grooming, eating, money management, transportation, or recreation. Services also include being aware of an individual's general whereabouts at all times and monitoring the activities of the individual to ensure the individual's health, safety, and welfare. The term "services" is synonymous with "care".

(82) "Services Coordinator" means an employee of a community developmental disability program or other agency that contracts with the county or Department, who is selected to plan, procure, coordinate, and monitor Individual Support Plan services, and to act as a proponent for individuals.

(83) "Significant Other" means a person selected by an individual to be the individual's friend.

(84) "Specialized Diet" means that the amount, type of ingredients, or selection of food or drink items is limited, restricted, or otherwise regulated under a physician's order. Examples include but are not limited to low calorie, high fiber, diabetic, low salt, lactose free, or low fat diets. A specialized diet does not include a diet where extra or additional food is offered without physician's orders but may not be eaten, for example, offer prunes each morning at breakfast or include fresh fruit with each meal.

(85) "Staff" means paid employees responsible for providing services to individuals whose wages are paid in part or in full with funds sub-contracted with the community developmental disability program or contracted directly through the Department.

(86) "Substantiated" means an abuse investigation has been completed by the Department or the Department's designee and the preponderance of the evidence establishes the abuse occurred.

(87) "Support" means the assistance that an individual requires, solely because of the affects of an intellectual or developmental disability, to maintain or increase independence, achieve community presence and participation, and improve productivity. Support is subject to change with time and circumstances.

(88) "Suspension" means an immediate temporary withdrawal of the approval to operate 24-hour residential services after the Department determines a service provider or 24-hour home is not in compliance with one or more of these rules or the rules in OAR chapter 411, division 323.

(89) "These Rules" mean the rules in OAR chapter 411, division 325.

(90) "Transfer" means movement of an individual from one home to another home administered or operated by the same service provider.

(91) "Transition Plan" means the written plan of services and supports for the period of time between an individual's entry into a particular service and the development of the individual's Individual Support Plan (ISP) . The Transition Plan is approved by the individual's services coordinator and includes a summary of the services necessary to facilitate adjustment to the services offered, the supports necessary to ensure health and safety, and the assessments and consultations necessary for ISP development.

(92) "Unusual Incident" means any incident involving an individual that includes serious illness or accidents, death, injury or illness requiring inpatient or emergency hospitalization, suicide attempts, a fire requiring the services of a fire department, or any incident requiring an abuse investigation.

(93) "Variance" means the temporary exception from a regulation or provision of these rules that may be granted by the Department upon written application by a service provider.

(94) "Volunteer" means any person assisting a service provider without pay to support the services and supports provided to an individual.

Stat. Auth.: ORS 409.050, 410.070, 443.450, & 443.455

Stats. Implemented: ORS 443.400 - 443.455

Hist.: SPD 25-2003, f. 12-29-03, cert. ef. 1-1-04; SPD 25-2004, f. 7-30-04, cert. ef. 8-1-04; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 5-2010, f. 6-29-10, cert. ef. 7-1-10; SPD 19-2011(Temp), f. & cert. ef. 7-1-11 thru 12-28-11; SPD 1-2012, f. & cert. ef. 1-6-12; SPD 23-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-325-0390

Entry, Exit and Transfer: General

(1) NON-DISCRIMINATION. An individual considered for Department-funded services may not be discriminated against because of race, color, creed, age, disability, national origin, duration of Oregon residence, method of payment, or other forms of discrimination under applicable state or federal law.

(2) QUALIFICATIONS FOR DEPARTMENT-FUNDED SERVICES PRIOR TO JULY 1, 2013. An individual considered for Department-funded services prior to July 1, 2013 must:

(a) Be referred by the Community Developmental Disability Program; and

(b) Be determined to have an intellectual or developmental disability by the Department or the Department's designee.

(3) QUALIFICATIONS FOR DEPARTMENT-FUNDED SERVICES ON OR AFTER JULY 1, 2013. An individual who enters 24-hour residen-

tial services on or after July 1, 2013, is subject to eligibility as described in this section.

(a) To be eligible for home and community-based waivered services or Community First Choice state plan services, an individual must:

(A) Be an Oregon resident;

(B) Be eligible for OSIP-M;

(C) Be determined eligible for developmental disability services by the CDDP of the individual's county of residence as described in OAR 411-320-0080; and

(D) After completion of an assessment, meet the level of care as defined in OAR 411-325-0020.

(b) To be eligible for 24-hour residential services, an individual must:

(A) Be an Oregon resident;

(B) Be determined eligible for developmental disability services by the CDDP of the individual's county of residence as described in OAR 411-320-0080;

(C) Be an individual who is not receiving other Department-funded in-home or community living support; and

(D) Be eligible for home and community-based waivered services or Community First Choice state plan services as described in subsection (a) of this section; OR

(E) Be determined to meet crisis eligibility as defined in OAR 411-320-0160.

(4) AUTHORIZATION OF ENTRY.

(a) The Department authorizes entry into children's residential services and state operated community programs.

(b) The CDDP services coordinator, except in the cases of children's residential services and state operated community programs, authorizes entry into 24-hour residential programs.

(5) DOCUMENTATION UPON ENTRY.

(a) A service provider must acquire the following information prior to or upon an entry ISP team meeting:

(A) A copy of the individual's eligibility determination document;

(B) A statement indicating the individual's safety skills including the individual's ability to evacuate from a building when warned by a signal device and adjust water temperature for bathing and washing;

(C) A brief written history of the individual's behavioral challenges, if any, including supervision and support needs;

(D) The individual's medical history and information on health care supports that include, where available:

(i) The results of a physical exam made within 90 days prior to entry;

(ii) Results of any dental evaluation;

(iii) A record of immunizations;

(iv) A record of known communicable diseases and allergies; and

(v) A record of major illnesses and hospitalizations.

(E) A written record of the individual's current or recommended medications, treatments, diets, and aids to physical functioning;

(F) Copies of documents relating to the individual's guardianship or conservatorship, health care representation, or any other legal restrictions on the rights of the individual, if applicable;

(G) Written documentation that the individual is participating in out of residence activities including school enrollment for individuals under the age of 21; and

(H) A copy of the individual's most recent Functional Behavioral Assessment, Behavior Support Plan, Individual Support Plan, and Individual Education Plan if applicable.

(b) If an individual is being admitted from the individual's family home and the information required in OAR 411-325-0390(5)(a)(A)-(H) of this section is not available, the service provider must assess the individual upon entry for issues of immediate health or safety and document a plan to secure the remaining information no later than 30 days after entry. Documentation of the assessment must include a written justification as to why the information is not available.

(6) ENTRY MEETING. An entry ISP team meeting must be conducted prior to the onset of services to an individual. The findings of the meeting must be recorded in the individual's file and include at a minimum:

(a) The name of the individual proposed for services;

(b) The date of the meeting and the date determined to be the individual's date of entry;

(c) The name and role of each participant at the meeting;

(d) Documentation of the pre-entry information required by OAR 411-325-0390(5)(a)(A)–(H) of this rule;

(e) Documentation of the decision to serve or not serve the individual requesting service including the reason for the determination to not serve the individual; and

(f) If the decision was made to serve the individual, a written transition plan for no longer than 60 days that includes all medical, behavior, and safety supports needed by the individual.

(7) VOLUNTARY TRANSFERS AND EXITS.

(a) If an individual or the individual's legal representative gives notice of the individual's intent to exit, or the individual abruptly exits, the service provider must promptly notify the individual's services coordinator.

(b) A service provider must notify an individual's ISP team prior to an individual's voluntary transfer or exit from services.

(c) Notification and authorization of an individual's voluntary transfer or exit must be documented in the individual's record.

(d) A service provider is responsible for the provision of services until an individual exits the home.

(8) INVOLUNTARY TRANSFERS AND EXITS.

(a) A service provider may only transfer or exit an individual involuntarily for one or more of the following reasons:

(A) To protect the health, safety, and welfare of the individual or others in the home;

(B) The individual's service needs exceed the ability of the service provider;

(C) The individual fails to pay for services; or

(D) The service provider's developmental disability certification or endorsement as described in OAR chapter 411, division 323 is suspended, revoked, not renewed, or voluntarily surrendered.

(b) NOTICE OF INVOLUNTARY TRANSFER OR EXIT. A service provider may not transfer or exit an individual involuntarily without 30 days advance written notice to the individual and the individual's legal representative and services coordinator except in the case of a medical emergency or when an individual is engaging in behavior that poses an imminent danger to self or others in the home as described in subsection (c) of this section.

(A) The written notice must be provided on a form approved by the Department (form SDS 0719) and include:

(i) The reason for the transfer or exit; and

(ii) The individual's right to a hearing as described in subsection (e) of this section.

(B) A notice is not required when an individual or the individual's legal representative requests a transfer or exit.

(c) A service provider may give less than 30 days advanced written notice only in a medical emergency or when an individual is engaging in behavior that poses an imminent danger to self or others in the home. The notice must be provided to the individual and the individual's legal representative and CDDP services coordinator immediately upon determination of the need for a transfer or exit.

(d) A service provider is responsible for the provision of services until an individual exits the home.

(e) HEARING RIGHTS. An individual must be given the opportunity for a contested case hearing under ORS 183 to dispute an involuntary transfer or exit. If an individual or the individual's representative requests a hearing, the individual must receive the same services until the hearing is resolved. When an individual has been given less than 30 days advanced written notice of an exit or transfer as described in subsection (c) of this section and the individual or the individual's representative has requested a hearing, the service provider must reserve the individual's room until receipt of the Final Order.

(9) EXIT MEETING.

(a) An individual's ISP team must meet before any decision to exit is made. Findings of such a meeting must be recorded in the individual's file and include, at a minimum:

(A) The name of the individual considered for exit;

(B) The date of the meeting;

(C) Documentation of the participants included in the meeting;

(D) Documentation of the circumstances leading to the proposed exit;

(E) Documentation of the discussion of strategies to prevent the individual's exit from service (unless the individual or the individual's legal representative is requesting the exit);

(F) Documentation of the decision regarding the individual's exit including verification of the voluntary decision to exit or a copy of the Notice of Involuntary Transfer or Exit; and

(G) Documentation of the proposed plan for services for the individual after the exit.

(b) WAIVER OF EXIT MEETING. Requirements for an exit meeting may be waived if an individual is immediately removed from the home under the following conditions:

(A) The individual or the individual's legal representative requests an immediate move from the home; or

(B) The individual is removed by legal authority acting pursuant to civil or criminal proceedings other than detention for an individual less than 18 years of age.(10) TRANSFER MEETING. A meeting of the ISP Team to discuss any proposed transfer of an individual must precede the decision to transfer. Findings of such a meeting must be recorded in the individual's file and include at a minimum:

(a) The name of the individual considered for transfer;

(b) The date of the meeting or telephone call;

(c) Documentation of the participants included in the meeting or telephone call;

(d) Documentation of the circumstances leading to the proposed transfer;

(e) Documentation of the alternatives considered instead of transfer;

(f) Documentation of the reasons any preferences of the individual or the individual's guardian, legal representative, parent, or family members cannot be honored;

(g) Documentation of the decision regarding the individual's transfer including verification of the voluntary decision to transfer or a copy of the Notice of Involuntary Transfer or Exit; and

(h) The individual's written plan for services after transfer.

Stat. Auth.: ORS 410.070 & 409.050
Stats. Implemented: ORS 443.400 - 443.455
Hist.: SPD 25-2003, f. 12-29-03, cert. ef. 1-1-04; SPD 25-2004, f. 7-30-04, cert. ef. 8-1-04; SPD 23-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-325-0400
Grievance of Entry, Exit and Transfer

(1) In cases where the individual or the individual's legal representative objects to, or the ISP team cannot reach majority agreement regarding an entry refusal, a grievance may be filed by any member of the ISP team. In the case of a refusal to serve, the program vacancy may not be permanently filled until the grievance is resolved.

(2) All grievances must be made in writing to the CDDP Director or the CDDP Director's designee in accordance with the CDDP's dispute resolution policy. The CDDP must provide a written response to the individual or the individual's legal representative within the timelines specified in the CDDP's dispute resolution policy.

(3) In cases where the CDDP's decision is in dispute, a written grievance must be made to the Department within ten days of receipt of the CDDP's decision.

(4) Unresolved grievances are reviewed by the Director or the Director's Designee and a written response is provided within 45 days of receipt of the written request for the Department's review. The decision of the Director or the Director's designee is final.

(5) Documentation of each grievance and resolution must be filed or noted in the individual's record.

Stat. Auth.: ORS 410.070 & 409.050
Stats. Implemented: ORS 443.400 - 443.455
Hist.: SPD 25-2003, f. 12-29-03, cert. ef. 1-1-04; SPD 25-2004, f. 7-30-04, cert. ef. 8-1-04; SPD 23-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-325-0440
Children's Direct Contracted Services

Any documentation or information required for children's direct contracted developmental disability services must be submitted to the CDDP Services Coordinator and the Department's Residential Services Coordinator assigned to the home or facility.

Stat. Auth.: ORS 410.070 & 409.050
Stats. Implemented: ORS 443.400 - 443.455
Hist.: SPD 25-2003, f. 12-29-03, cert. ef. 1-1-04; SPD 25-2004, f. 7-30-04, cert. ef. 8-1-04; SPD 23-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

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Rule Caption: Supported Living Services for Adults with Intellectual or Developmental Disabilities
Adm. Order No.: SPD 24-2013(Temp)
Filed with Sec. of State: 7-1-2013
Certified to be Effective: 7-1-13 thru 12-28-13
Notice Publication Date:
Rules Amended: 411-328-0560, 411-328-0790, 411-328-0800
Subject: The Department of Human Services (Department) is immediately amending the supported living services rules for adults with intellectual or developmental disabilities in OAR chapter 411, division 328 to:

Specify the eligibility requirements for home and community-based waivered services to reflect changes made as a result of the Department's Community First Choice State Plan; and

Clarify the notice requirements and hearing rights for involuntary transfers and exits to comply with the Code of Federal Regulations and implement corrective actions required as a result of the Centers for Medicare and Medicaid Services' (CMS) review of the Department's Home and Community-Based Services Waiver.
Rules Coordinator: Christina Hartman—(503) 945-6398

411-328-0560
Definitions

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 328:

(1) "Abuse" means abuse of an adult as defined in OAR 407-045-0260.

(2) "Abuse Investigation and Protective Services" means reporting and investigation activities as required by OAR 407-045-0300 and any subsequent services or supports necessary to prevent further abuse as required in OAR 407-045-0310.

(3) "Administration of Medication" means the act of placing a medication in or on an individual's body by a staff member who is responsible for the individual's care.

(4) "Adult" means an individual 18 years or older with an intellectual or developmental disability.

(5) "Advocate" means a person other than paid staff who has been selected by an individual or by the individual's legal representative to help the individual understand and make choices in matters relating to identification of needs and choices of services, especially when rights are at risk or have been violated.

(6) "Aid to Physical Functioning" means any special equipment prescribed for an individual by a physician, therapist, or dietician that maintains or enhances the individual's physical functioning.

(7) "Annual Individual Support Plan (ISP) Meeting" means an annual meeting, facilitated by an individual's services coordinator and attended by an individual's ISP team. The purpose of the meeting is to determine an individual's needs, coordinate services and training, and develop the individual's ISP.

(8) "Board of Directors" mean the group of persons formed to set policy and give directions to a service provider that provides supported living services. A board of directors includes local advisory boards used by multistate organizations.

(9) "Case Management" means an organized service to assist individuals to select, obtain, and utilize resources and services.

(10) "CDDP" means "Community Developmental Disability Program" as defined in this rule.

(11) "Certificate" means the document issued by the Department to a service provider that certifies the service provider is eligible under the rules in OAR chapter 411, division 323 to receive state funds for the provision of endorsed supported living services.

(12) "Choice" means an individual's expression of preference, opportunity for, and active role in decision-making related to services received and from whom, including but not limited to case management, service providers, and service settings. Personal outcomes, goals, and activities are supported in the context of balancing an individual's rights, risks, and personal choices. Individuals are supported in opportunities to make changes when so expressed. Choice may be communicated verbally, through sign language, or by other communication methods.

(13) "Community Developmental Disability Program (CDDP)" means the entity that is responsible for the planning and delivery of services for individuals with intellectual or developmental disabilities according to OAR chapter 411, division 320. A CDDP operates in a specific geographic service area of the state under a contract with the Department, local mental health authority, or other entity as contracted by the Department.

(14) "Community First Choice State Plan" means Oregon's state plan amendment authorized under section 1915(k) of the Social Security Act.

(15) "Complaint Investigation" means the investigation of any complaint that has been made to a proper authority that is not covered by an abuse investigation.

(16) "Controlled Substance" means any drug classified as Schedules 1 through 5 under the Federal Controlled Substance Act.

(17) "Department" means the Department of Human Services (DHS). The term "Department" is synonymous with "Seniors and People with Disability Division (Division)(SPD)".

(18) "Developmental Disability" means a neurological condition that originates in the developmental years, that is likely to continue, and significantly impacts adaptive behavior as diagnosed and measured by a qualified professional as described in OAR 411-320-0080.

(19) "Director" means the Director of the Department's Office of Developmental Disability Services or the Director's designee. The term "Director" is synonymous with "Assistant Director".

(20) "Endorsement" means the authorization to provide supported living services issued by the Department to a certified service provider that has met the qualification criteria outlined in these rules and the rules in OAR chapter 411, division 323.

(21) "Entry" means admission to a Department-funded developmental disability service.

(22) "Executive Director" means the person designated by a board of directors or corporate owner that is responsible for the administration of supported living services.

(23) "Exit" means termination or discontinuance of:

(a) Services from a service provider; or

(b) Department-funded developmental disability services.

(24) "Founded Reports" means the Department's or Law Enforcement Authority's (LEA) determination, based on the evidence, that there is reasonable cause to believe that conduct in violation of the child abuse statutes or rules has occurred and such conduct is attributable to a person alleged to have engaged in the conduct.

(25) "Functional Needs Assessment (FNAT)" means an assessment that documents the level of need, accommodates an individual's participation in service planning, and includes:

(a) Completing a comprehensive and holistic assessment;

(b) Surveying physical, mental, and social functioning; and

(c) Identifying risk factors, choices and preferences, and service needs.

(26) "Health Care Provider" means the person or health care facility licensed, certified, or otherwise authorized or permitted by Oregon law to administer health care in the ordinary course of business or practice of a profession.

(27) "Home and Community-Based Waivered Services" mean the services approved by the Centers for Medicare and Medicaid Services in accordance with Sections 1915(c) and 1115 of the Social Security Act.

(28) "Incident Report" means the written report of any injury, accident, acts of physical aggression, or unusual incident involving an individual.

(29) "Independence" means the extent to which individuals exert control and choice over their own lives.

(30) "Individual" means an adult with an intellectual or developmental disability applying for or determined eligible for developmental disability services.

(31) "Individual Profile" means the written profile that describes an individual entering into supported living services. The profile may consist of materials or assessments generated by a service provider or other related agencies, consultants, family members, or advocates.

(32) "Individual Support Plan (ISP)" means the written details of the supports, activities, and resources required for an individual to achieve personal outcomes. Individual support needs are identified through a Functional Needs Assessment. The manner in which services are delivered, service providers, and the frequency of services are reflected in an ISP. The ISP is developed at minimum annually to reflect decisions and agreements made during a person-centered process of planning and information gathering. The ISP includes an individual's Plan of Care for Medicaid purposes and reflects whether services are purchased through a waiver, state plan, or provided through an individual's natural supports.

(33) "Individual Support Plan (ISP) Team" means a team composed of an individual receiving services and the individual's legal representative, services coordinator or personal agent, and others chosen by the individual. Others chosen by the individual may include service providers, family members, or other persons requested by the individual.

(34) "Integration" as defined in ORS 427.005 means:

(a) The use by individuals with intellectual or developmental disabilities of the same community resources used by and available to other persons;

(b) Participation by individuals with intellectual or developmental disabilities in the same community activities in which persons without an intellectual or developmental disability participate, together with regular contact with persons without an intellectual or developmental disability; and

(c) Individuals with intellectual or developmental disabilities reside in homes or home-like settings that are in proximity to community resources and foster contact with persons in the community.

(35) "Intellectual Disability" has the meaning set forth in OAR 411-320-0020 and described in 411-320-0080.

(36) "Involuntary Transfer" means a service provider has made the decision to transfer an individual and the individual or the individual's legal representative has not given prior approval.

(37) "ISP" means "Individual Support Plan" as defined in this rule.

(38) "Legal Representative" means an attorney at law who has been retained by or for an individual or a person or agency authorized by a court to make decisions about services for an individual.

(39) "Level of Care" means an assessment completed by a services coordinator has determined an individual meets institutional level of care. An individual meets institutional level of care for an intermediate care facility for individuals with intellectual or developmental disabilities if:

(a) The individual has a condition of an intellectual disability or a developmental disability as defined in OAR 411-320-0020 and meets the eligibility criteria for developmental disability services as described in OAR 411-320-0080; and

(b) The individual has a significant impairment in one or more areas of adaptive functioning. Areas of adaptive functioning include self direction, self care, home living, community use, social, communication, mobility, or health and safety.

(40) "Mandatory Reporter" means any public or private official as defined in OAR 407-045-0260 who, is a staff or volunteer working with an adult with an intellectual or developmental disability who, while acting in an official capacity, comes in contact with and has reasonable cause to believe an adult with an intellectual or developmental disability has suffered abuse, or comes in contact with any person whom the official has reasonable cause to believe abused an adult with an intellectual or developmental disability. Nothing contained in ORS 40.225 to 40.295 affects the duty to report imposed by this section of this rule, except that a psychiatrist, psychologist, clergy, or attorney is not required to report if the communication is privileged under ORS 40.225 to 40.295.

(41) "Medicaid Agency Identification Number" means the numeric identifier assigned by the Department to a service provider following the service provider's enrollment as described in OAR chapter 411, division 370.

(42) "Medicaid Performing Provider Number" means the numeric identifier assigned to an entity or person by the Department, following enrollment to deliver Medicaid funded services as described in OAR chapter 411, division 370. The Medicaid Performing Provider Number is used by the rendering service provider for identification and billing purposes associated with service authorizations and payments.

(43) "Medication" means any drug, chemical, compound, suspension, or preparation in suitable form for use as a curative or remedial substance taken either internally or externally by any person.

(44) "Natural Supports" or "Natural Support System" means the resources available to an individual from the individual's relatives, friends, significant others, neighbors, roommates, and the community. Services provided by natural supports are resources that are not paid for by the Department.

(45) "Needs Meeting" means a process in which an Individual Support Plan team defines the services and supports an individual needs to live in his or her own home, and makes a determination as to the feasibility of creating such services. The information generated in a needs meeting or discussion is used by a service provider to develop an individual's Transition Plan.

(46) "OSIP-M" means Oregon Supplemental Income Program-Medical as defined in OAR 461-101-0010. OSIP-M is Oregon Medicaid insurance coverage for an individual who meets eligibility criteria as described in OAR chapter 461.

(47) "Personal Futures Planning" means an optional planning process for determining activities, supports, and resources that best create a desirable future for an individual . The planning process generally occurs around major life transitions (e.g. moving into a new home, graduation from high school, marriage, etc.).

(48) "Person-Centered Planning" means:

(a) A process, either formal or informal, for gathering and organizing information that helps an individual:

(A) Determine and describe choices about personal goals, activities, and lifestyle preferences;

(B) Design strategies and networks of support to achieve goals and a preferred lifestyle using individual strengths, relationships, and resources; and

(C) Identify, use, and strengthen naturally occurring opportunities for support at home and in the community.

(b) The methods for gathering information vary, but all are consistent with individual needs and preferences.

(49) "Prescription Medication" means any medication that requires a physician's prescription before the medication may be obtained from a pharmacist.

(50) "Productivity" as defined in ORS 427.005 means:

(a) Engagement in income-producing work by an individual that is measured through improvements in income level, employment status, or job advancement; or

(b) Engagement by an individual in work contributing to a household or community.

(51) "Protection" and "Protective Services" means necessary actions taken as soon as possible to prevent subsequent abuse or exploitation of an individual, to prevent self-destructive acts, or to safeguard an individual's person, property, and funds.

(52) "Protective Physical Intervention (PPI)" means any manual physical holding of, or contact with, an individual that restricts the individual's freedom of movement. The term "protective physical intervention" is synonymous with "physical restraint".

(53) "Psychotropic Medication" means medication the prescribed intent of which is to affect or alter thought processes, mood, or behavior including but not limited to anti-psychotic, antidepressant, anxiolytic (anti-anxiety), and behavior medications. The classification of a medication depends upon its stated, intended effect when prescribed.

(54) "Self-Administration of Medication" means an individual manages and takes his or her own medication, identifies his or her own medication and the times and methods of administration, places the medication internally in or externally on his or her own body without staff assistance upon written order of a physician, and safely maintains the medication without supervision.

(55) "Service Provider" means a public or private community agency or organization that provides recognized developmental disability services and is certified and endorsed by the Department to provide these services under these rules and the rules in OAR chapter 411, division 323. The use of the terms "agency", "provider", or "program" are synonymous with "service provider."

(56) "Services Coordinator" means an employee of a community developmental disability program or other agency that contracts with the county or Department, who is selected to plan, procure, coordinate, and monitor Individual Support Plan services, and to act as a proponent for individuals.

(57) "Significant Other" means a person selected by an individual to be the individual's friend.

(58) "Staff" means paid employees responsible for providing services to individuals whose wages are paid in part or in full with funds sub-contracted with the community developmental disability program or contracted directly through the Department.

(59) "Substantiated" means an abuse investigation has been completed by the Department or the Department's designee and the preponderance of the evidence establishes the abuse occurred.

(60) "Support" means the assistance that an individual requires, solely because of the affects of an intellectual or developmental disability, to maintain or increase independence, achieve community presence and participation, and improve productivity. Support is subject to change with time and circumstances.

(61) "Supported Living" means the endorsed service that provides the opportunity for individuals to live in a residence of their own choice within the community. Supported living is not grounded in the concept of "readiness" or in a "continuum of services model" but rather provides the opportunity for individuals to live where they want, with whom they want, for as long as they desire, with a recognition that needs and desires may change over time.

(62) "These Rules" mean the rules in OAR chapter 411, division 328.

(63) "Transfer" means movement of an individual from one type of service to another type of service administered or operated by the same service provider.

(64) "Transition Plan" means the written plan of services and supports for the period of time between an individual's entry into a particular service and the development of the individual's Individual Support Plan(ISP). The Transition Plan is approved by the individual's services coordinator and includes a summary of the services necessary to facilitate adjustment to the services offered, the supports necessary to ensure health and safety, and the assessments and consultations necessary for ISP development.

(65) "Unusual Incident" means any incident involving an individual that includes serious illness or accidents, death, injury or illness requiring inpatient or emergency hospitalization, suicide attempts, a fire requiring the services of a fire department, or any incident requiring an abuse investigation.

(66) "Variance" means the temporary exception from a regulation or provision of these rules that may be granted by the Department upon written application by a service provider.

(67) "Volunteer" means any person assisting a service provider without pay to support the services provided to an individual.

Stat. Auth.: ORS 409.050 & 410.070
Stats. Implemented: ORS 430.610, 430.630 & 430.670
Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97; Renumbered from 309-041-0560 by SPD 17-2009, f. & cert. ef. 12-9-09; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 5-2010, f. 6-29-10, cert. ef. 7-1-10; SPD 19-2011(Temp), f. & cert. ef. 7-1-11 thru 12-28-11; SPD 1-2012, f. & cert. ef. 1-6-12; SPD 24-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-328-0790
Entry, Exit and Transfer: General

(1) NON-DISCRIMINATION. An individual considered for Department-funded services may not be discriminated against because of race, color, creed, age, disability, national origin, gender, religion, duration of Oregon residence, method of payment, or other forms of discrimination under applicable state or Federal law.

(2) QUALIFICATIONS FOR DEPARTMENT-FUNDED SERVICES PRIOR TO JULY 1, 2013. An individual considered for Department-funded services prior to July 1, 2013 must:

(a) Be referred by the Community Developmental Disability Program; and

(b) Be determined to have an intellectual or developmental disability by the Department or the Department's designee.

(3) QUALIFICATIONS FOR DEPARTMENT-FUNDED SERVICES ON OR AFTER JULY 1, 2013. An individual who enters supported living services on or after July 1, 2013, is subject to eligibility as described in this section.

(a) To be eligible for home and community-based waivered services or Community First Choice State Plan services, an individual must:

(A) Be an Oregon resident; and

(B) Be eligible for OSIP-M; and

(C) Be determined eligible for developmental disability services by the CDDP of the individual's county of residence as described in OAR 411-320-0080; and

(D) After completion of an assessment, meet the level of care as defined in OAR 411-328-0560.

(b) To be eligible for supported living services, an individual must:

(A) Be an Oregon resident;

(B) Be determined eligible for developmental disability services by the CDDP of the individual's county of residence as described in OAR 411-320-0080;

(C) Be an individual who is not receiving other Department-funded in-home or community living support;

(D) Have access to the financial resources to pay for food, utilities, and housing expenses; and

(E) Be eligible for home and community-based waivered services or Community First Choice State Plan services as described in subsection (a) of this section; OR

(F) Be determined to meet crisis eligibility as defined in OAR 411-320-0160.

(4) DOCUMENTATION UPON ENTRY. A service provider must acquire the following information prior to or upon an individual's entry ISP team meeting:

(a) A copy of the individual's eligibility determination document;

(b) A statement indicating the individual's safety skills including the individual's ability to evacuate from a building when warned by a signal device and adjust water temperature for bathing and washing;

(c) A brief written history of the individual's medical conditions or behavioral challenges, if any, including supervision and support needs;

(d) Information related to the individual's lifestyle, activities, and other choices and preferences;

(e) Documentation of the individual's financial resources;

(f) Documentation from a physician of the individual's current physical condition, including a written record of any current or recommended medications, treatments, diets, and aids to physical functioning;

(g) Documentation of any guardianship or conservatorship, health care representation, or any other legal restriction on the rights of the individual, if applicable; and

(h) A copy of the individual's most recent ISP, if applicable.

(5) ENTRY MEETING. An entry ISP team meeting must be conducted prior to the onset of services to an individual. The findings of the entry meeting must be recorded in the individual's file and include at a minimum:

(a) The name of the individual proposed for services;

(b) The date of the meeting;

(c) The date determined to be the individual's date of entry;

(d) Documentation of the participants at the meeting;

(e) Documentation of the pre-entry information required by section (4)(a-h) of this rule;

(f) Documentation of the decision to serve or not serve the individual requesting services, including the reason for the determination to not serve the individual; and

(g) If the decision was made to serve the individual, a written transition plan for the services to be provided.

(6) VOLUNTARY TRANSFERS AND EXITS.

(a) If an individual or the individual's legal representative gives notice of the individual's intent to exit, or the individual abruptly exits services, the service provider must promptly notify the individual's CDDP services coordinator.

(b) A service provider must notify an individual's ISP team prior to an individual's voluntary transfer or exit from services.

(c) Notification and authorization of an individual's voluntary transfer or exit must be documented in the individual's record.

(7) INVOLUNTARY TRANSFERS AND EXITS.

(a) A service provider may only transfer or exit an individual involuntarily for one or more of the following reasons:

(A) To protect the health, safety, and welfare of the individual or others;

(B) The individual's service needs exceed the ability of the service provider;

(C) The individual fails to pay for services; or

(D) The service provider's developmental disability certification or endorsement as described in OAR chapter 411, division 323 is suspended, revoked, not renewed, or voluntarily surrendered.

(b) NOTICE OF INVOLUNTARY TRANSFER OR EXIT. A service provider may not transfer or exit an individual involuntarily without 30 days advance written notice to the individual and the individual's legal representative and CDDP services coordinator except in the case of a medical emergency or when an individual is engaging in behavior that poses an imminent danger to self or others as described in subsection (c) of this section.

(A) The written notice must be provided on a form approved by the Department (form SDS 0719) and include:

(i) The reason for the transfer or exit; and

(ii) The individual's right to a hearing as described in subsection (d) of this section.

(B) A notice is not required when an individual or the individual's legal representative requests a transfer or exit.

(c) A service provider may give less than 30 days advanced written notice only in a medical emergency or when an individual is engaging in behavior that poses an imminent danger to self or others. The notice must be provided to the individual and the individual's legal representative and CDDP services coordinator immediately upon determination of the need for a transfer or exit.

(d) HEARING RIGHTS. An individual must be given the opportunity for a contested case hearing under ORS 183 to dispute an involuntary transfer or exit. If an individual or the individual's representative requests a hearing, the individual must receive the same services until the hearing is resolved. When an individual has been given less than 30 days advanced written notice of an exit or transfer as described in subsection (c) of this section and the individual or the individual's representative has requested a hearing, the service provider must reserve service availability for the individual until receipt of the Final Order.

(8) EXIT MEETING.

(a) An individual's ISP team must meet before any decision to exit is made. Findings of such a meeting must be recorded in the individual's file and include at a minimum:

(A) The name of the individual considered for exit;

(B) The date of the meeting;

(C) Documentation of the participants included in the meeting;

(D) Documentation of the circumstances leading to the proposed exit;

(E) Documentation of the discussion of the strategies to prevent the individual's exit from services (unless the individual or the individual's legal representative is requesting the exit);

(F) Documentation of the decision regarding the individual's exit including verification of the voluntary decision to transfer or exit or a copy of the Notice of Involuntary Transfer or Exit; and

(G) Documentation of the proposed plan for services for the individual after the exit.

(b) WAIVER OF EXIT MEETING. Requirements for an exit meeting may be waived if an individual is immediately removed from services under the following conditions:

(A) The individual or the individual's legal representative requests an immediate removal; or

(B) The individual is removed by legal authority acting pursuant to civil or criminal proceedings.

(9) TRANSFER MEETING. A meeting of the ISP Team to discuss any proposed transfer of an individual must precede the decision to transfer. Findings of such a meeting must be recorded in the individual's file and include at a minimum:

(a) The name of the individual considered for transfer;

(b) The date of the meeting or telephone call;

(c) Documentation of the participants included in the meeting or telephone call;

(d) Documentation of the circumstances leading to the proposed transfer;

(e) Documentation of the alternatives considered instead of transfer;

(f) Documentation of the reasons any preferences of the individual or the individual's legal representative or family members cannot be honored;

(g) Documentation of a majority agreement of the participants regarding the decision; and

(h) The individual's written plan for services after transfer.

Stat. Auth.: ORS 409.050 & 410.070

Stats. Implemented: ORS 430.610, 430.630 & 430.670

Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97; Renumbered from 309-041-0790 by SPD 17-2009, f. & cert. ef. 12-9-09; SPD 24-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-328-0800

Rights: Entry, Exit and Transfer: Appeal Process

(1) In cases where the individual and the individual's parent, guardian, advocate, or the provider objects to, or the ISP team cannot reach majority agreement regarding an admission refusal, an appeal may be filed by any member of the ISP team. In the case of a refusal to serve, the slot must be held vacant but the payment for the slot must continue.

(2) All appeals must be made in writing to the CDDP Director or the CDDP Director's designee for decision using the county's appeal process. The CDDP Director or the CDDP Director's designee must make a decision within 30 working days of receipt of the appeal and notify the appellant of the decision in writing.

(3) The decision of the CDDP may be appealed by the individual, the individual's parent, guardian, advocate, or the provider by notifying the Office of Developmental Disability Services in writing within ten working days of receipt of the county's decision.

(a) A committee is appointed by the Director or the Director's designee in the Office of Developmental Disability Services every two years and is composed of a Department representative, a residential service representative, and a services coordinator;

(b) In case of a conflict of interest, as determined by the Director or the Director's designee, alternative representatives may be temporarily appointed by the Director or the Director's designee to the committee;

(c) The committee reviews the appealed decision and makes a written recommendation to the Director or the Director's designee within 45 working days of receipt of the notice of appeal;

(d) The Director or the Director's designee makes a decision on the appeal within ten working days after receipt of the recommendation from the committee; and

(e) If the decision is for admission or continued placement and the provider refuses admission or continued placement, the funding for the slot may be withdrawn by the contractor.

Stat. Auth.: ORS 409.050 & 410.070

Stats. Implemented: ORS 430.610, 430.630 & 430.670

Hist.: MHD 5-1992, f. 8-21-92, cert. ef. 8-24-92; MHD 3-1997, f. & cert. ef. 2-7-97; Renumbered from 309-041-0800 by SPD 17-2009, f. & cert. ef. 12-9-09; SPD 24-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

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Rule Caption: Comprehensive In-Home Support for Adults with Intellectual or Developmental Disabilities

Adm. Order No.: SPD 25-2013(Temp)
Filed with Sec. of State: 7-1-2013
Certified to be Effective: 7-1-13 thru 12-28-13
Notice Publication Date:
Rules Amended: 411-330-0020, 411-330-0030, 411-330-0040, 411-330-0050, 411-330-0060, 411-330-0070, 411-330-0080, 411-330-0090, 411-330-0110
Subject: The Department of Human Services (Department) is immediately amending the comprehensive in-home support rules for adults with intellectual or developmental disabilities in OAR chapter 411, division 330 to:

Reflect new definitions applicable to Community First Choice State Plan services;

Specify the eligibility requirements to reflect changes made as a result of the Community First Choice State Plan;

Describe and coincide with the services available in the Community First Choice State Plan and Home and Community-Based Waiver amendments;

Require a functional needs assessment as part of an individual's service planning process; and

Clarify the responsibilities of a services coordinator when developing an Individual Service Plan.
Rules Coordinator: Christina Hartman—(503) 945-6398

411-330-0020
Definitions

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 330:

(1) "Abuse" means abuse of an adult as defined in OAR 407-045-0260.

(2) "Abuse Investigation and Protective Services" means reporting and investigation activities as required by OAR 407-045-0300 and any subsequent services or supports necessary to prevent further abuse as required by OAR 407-045-0310.

(3) "Activities of Daily Living (ADL)" mean those personal, functional activities required by an individual for continued well-being that are essential for health and safety.

(4) "Adult" means an individual 18 years or older with an intellectual or developmental disability.

(5) "Advocate" means a person, other than paid staff, who has been selected by an individual, or by the individual's legal representative, to help the individual understand and make choices in matters relating to identification of needs and choices of services, especially when rights are at risk or have been violated.

(6) "Alternatives to Employment - Habilitation" means assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that takes place in a non-residential setting, separate from the home in which an individual with an intellectual or developmental disability resides.

(7) "Background Check" means a criminal records check and abuse check as defined in OAR 407-007-0210 (Criminal Records and Abuse Check for Providers).

(8) "Behavior Support Plan (BSP)" means a written strategy based on person-centered planning and a functional assessment that outlines specific instructions for a provider to follow, to cause a child's challenging behaviors to become unnecessary, and to change the provider's own behavior, adjust environment, and teach new skills.

(9) "Behavior Support Services" mean the services described in OAR 411-330-0110 that are provided to assist with behavioral challenges due to an individual's intellectual or developmental disability that prevents the individual from accomplishing activities of daily living, instrumental activities of daily living, and health related tasks.

(10) "Case Management" means an organized service to assist individuals to select, obtain, and utilize resources and services.

(11) "CDDP" means "Community Developmental Disability Program" as defined in this rule.

(12) "Choice" means an individual's expression of preference, opportunity for, and active role in decision-making related to services received and from whom, including but not limited to case management, service providers, and service settings. Personal outcomes, goals, and activities are supported in the context of balancing an individual's rights, risks, and personal choices. Individuals are supported in opportunities to make changes when so expressed. Choice may be communicated verbally, through sign language, or by other communication methods.

(13) "Chore Services" mean the services described in OAR 411-330-0110 needed to maintain a clean, sanitary, and safe environment in an individual's home. Chore services include heavy household chores such as washing floors, windows, and walls, tacking down loose rugs and tiles, and moving heavy items of furniture for safe access and egress. Chore services may include yard hazard abatement to ensure the outside of the home is safe for the individual to traverse and enter and exit the home.

(14) "Client Process Monitoring System (CPMS)" means the Department's computerized system for enrolling and terminating services for individuals with developmental disabilities.

(15) "Collective Bargaining Agreement" means a contract based on negotiation between organized workers and their designated employer for purposes of collective bargaining to determine wages, hours, rules, and working conditions.

(16) "Community Developmental Disability Program (CDDP)" means the entity that is responsible for the planning and delivery of services for individuals with developmental disabilities according to OAR chapter 411, division 320. A CDDP operates in a specific geographic service area of the state under a contract with the Department, local mental health authority, or other entity as contracted by the Department.

(17) "Community First Choice" means Oregon's state plan amendment authorized under section 1915(k) of the Social Security Act.

(18) "Community Nursing Services" mean the services described in OAR 411-330-0110 that include nurse delegation and care coordination for an individual living in his or her own home. Community nursing services do not include direct nursing care and are not covered by other Medicaid spending authorities

(19) "Comprehensive Services" mean developmental disability services and supports that include 24-hour residential services provided in a group home, foster home, or through a supported living program. Comprehensive services are regulated by the Department alone or in combination with an associated Department-regulated employment or community inclusion program. Comprehensive services are in-home services provided to an individual with an intellectual or developmental disability when the individual receives case management services from a community developmental disability program. Comprehensive services do not include support services for adults with developmental disabilities enrolled in brokerages..

(20) "Department" means the Department of Human Services (DHS). The term "Department" is synonymous with "Seniors and People with Disabilities Division (Division)(SPD)".

(21) "Developmental Disability" means a neurological condition that originates in the developmental years, that is likely to continue, and significantly impacts adaptive behavior as diagnosed and measured by a qualified professional as described in OAR 411-320-0080.

(22) "Director" means the Director of the Department's Office of Developmental Disability Services or the Director's designee. The term "Director" is synonymous with "Assistant Director".

(23) "Employer-Related Supports" mean activities that assist an individual and, when applicable, the individual's legal representative or family members, with directing and supervising provision of services described in the individual's In-Home Support Plan. Supports to the employer include but are not limited to:

(a) Education about employer responsibilities;

(b) Orientation to basic wage and hour issues;

(c) Use of common employer-related tools such as job descriptions; and

(d) Fiscal intermediary services.

(24) "Entry" means admission to a Department-funded developmental disability service.

(25) "Environmental Accessibility Adaptations" mean the physical adaptations as described in OAR 411-330-0110 that are necessary to ensure the health, welfare, and safety of an individual in the home, or that enable the individual to function with greater independence in the home.

(26) "Exit" means termination or discontinuance of:

(a) Services from a service provider; or

(b) Department-funded developmental disability services.

(27) "Family":

(a) Means a unit of two or more persons that includes at least one individual with an intellectual or developmental disability where the primary caregiver is:

(A) Related to the individual with an intellectual or developmental disability by blood, marriage, or legal adoption; or

(B) In a domestic relationship where partners share:

(i) A permanent residence;

(ii) Joint responsibility for the household in general (e.g. child-rearing, maintenance of the residence, basic living expenses); and

(iii) Joint responsibility for supporting the individual when the individual with an intellectual or developmental disability is related to one of the partners by blood, marriage, or legal adoption.

(b) The term "family" is defined as described above for purposes of:

(A) Determining an individual's eligibility for in-home support as a resident in the family home;

(B) Identifying persons who may apply, plan, and arrange for individual supports; and

(C) Determining who may receive family training.

(28) "Family Training" means training and counseling services for the family of an individual that increase the family's capacity to care for, support, and maintain the individual in the home as described in OAR 411-330-0110. Family training includes:

(a) Instruction about treatment regimens and use of equipment specified in an Individual Support Plan;

(b) Information, education, and training about the individual's intellectual or developmental disability, medical, or behavioral conditions; and

(c) Counseling for the family to relieve the stress associated with caring for an individual with an intellectual or developmental disability.

(29) "Fiscal Intermediary" means a person or entity that receives and distributes in-home support funds on behalf of an individual according to the individual's In-Home Support Plan. The fiscal intermediary acts as an agent for the individual or the individual's legal representative and performs activities and maintains records related to payroll and payment of employer-related taxes and fees. In this capacity, the fiscal intermediary does not recruit, hire, supervise, evaluate, dismiss, or otherwise discipline employees.

(30) "Founded Reports" means the Department's or Law Enforcement Authority's (LEA) determination, based on the evidence, that there is reasonable cause to believe that conduct in violation of the child abuse statutes or rules has occurred and such conduct is attributable to the person alleged to have engaged in the conduct.

(31) "Functional Needs Assessment (FNAT)" means an assessment that documents the level of need, accommodates an individual's participation in service planning, and includes:

(a) Completing a comprehensive and holistic assessment;

(b) Surveying physical, mental, and social functioning; and

(c) Identifying risk factors, choices and preferences, and service needs.

(32) "General Business Provider" means an organization or entity selected by an individual or the individual's legal representative, and paid with in-home support funds that:

(a) Is primarily in business to provide the service chosen by the individual to the general public;

(b) Provides services for the individual through employees, contractors, or volunteers; and

(c) Receives compensation to recruit, supervise, and pay the persons who actually provide support for the individual.

(33) "Home" means an individual's primary residence that is not under contract with the Department to provide services as a licensed, endorsed, or certified foster home, residential care facility, assisted living facility, nursing facility, or other residential support program site.

(34) "Home and Community Based Waivered Services" mean the services approved by the Centers for Medicare and Medicaid Services in accordance with Sections 1915(c) and 1115 of the Social Security Act.

(35) "IHS" means In-Home Support as defined in this rule.

(36) "Immediate Family" means for the purpose of determining whether in-home support funds may be used to pay a family member to provide services, the spouse of an adult with an intellectual or developmental disability.

(37) "Incident Report" means the written report of any injury, accident, acts of physical aggression, or unusual incident involving an individual.

(38) "Independence" means the extent to which individuals with intellectual or developmental disabilities exert control and choice over their own lives.

(39) "Independent Provider" means a person selected by an individual or the individual's legal representative and paid with in-home support funds to personally provide services to the individual.

(40) "Individual" means an adult with an intellectual or developmental disability applying for or determined eligible for developmental disability services.

(41) "In-Home Support (IHS)" means support that is:

(a) Required for an individual with an intellectual or developmental disability to live in his or her home or the family home;

(b) Designed, selected, and managed by the individual or the individual's legal representative; and

(c) Provided in accordance with an IHS Plan.

(42) "In-Home Support (IHS) Plan" means the written details of the supports, activities, and resources required for an individual to achieve personal outcomes and be supported by the family in the family home. An individual's support needs are identified through a functional needs assessment. The manner in which services are delivered, service providers, and the frequency of services are reflected in an IHS Plan. The IHS Plan is developed at minimum annually to reflect decisions and agreements made during a person-centered process of planning and information gathering. An individual's IHS Plan is the only plan of care required by the Department for an individual receiving in-home supports.

(43) "Instrumental Activities of Daily Living (IADL)" mean those activities, other than activities of daily living, required to continue independent living.

(44) "Integration" as defined in ORS 427.005 means:

(a) The use by individuals with intellectual or developmental disabilities of the same community resources used by and available to other persons;

(b) Participation by individuals with intellectual or developmental disabilities in the same community activities in which persons without an intellectual or developmental disability participate, together with regular contact with persons without an intellectual or developmental disability; and

(c) Individuals with intellectual or developmental disabilities reside in homes or home-like settings that are in proximity to community resources and foster contact with persons in the community.

(45) "Intellectual Disability" has the meaning set forth in OAR 411-320-0020 and described in OAR 411-320-0080.

(46) "Intervention" means the action the Department or the Department's designee requires when an individual or an individual's representative fails to meet the employer responsibilities described in OAR 411-330-0065. Intervention includes but is not limited to:

(a) A documented review of the employer responsibilities described in OAR 411-330-0065;

(b) Training related to employer responsibilities;

(c) Corrective action taken as a result of an independent provider filing a complaint with the Department, the Department's designee, or other agency who may receive labor related complaints;

(d) Identifying a representative if an individual is not able to meet the employer responsibilities described in OAR 411-330-0065; or

(e) Identifying another representative if an individual's current representative is not able to meet the employer responsibilities described in OAR 411-330-0065.

(47) "Legal Representative" means an attorney at law who has been retained by or for an individual, or a person or agency authorized by a court to make decisions about services for an individual.

(48) "Level of Care" means an assessment completed by a services coordinator has determined an individual meets institutional level of care. An individual meets institutional level of care for an intermediate care facility for individuals with intellectual or developmental disabilities if:

(a) The individual has a condition of an intellectual disability or a developmental disability as defined in OAR 411-320-0020 and meets the eligibility criteria for developmental disability services as described in 411-320-0080; and

(b) The individual has a significant impairment in one or more areas of adaptive functioning. Areas of adaptive functioning include self direction, self care, home living, community use, social, communication, mobility, or health and safety.

(49) "Local Mental Health Authority (LMHA)" means:

(a) The county court or board of county commissioners of one or more counties that operate a community developmental disability program;

(b) The tribal council in the case of a Native American reservation;

(c) The Board of Directors of a public or private corporation if the county declines to operate a contract for all or part of a community developmental disability program; or

(d) The advisory committee for the community developmental disability program covering a geographic service area when managed by the Department.

(50) "Mandatory Reporter" means any public or private official as defined in OAR 407-045-0260 who, while acting in an official capacity, comes in contact with and has reasonable cause to believe an adult with an intellectual or developmental disability has suffered abuse, or comes in contact with any person whom the official has reasonable cause to believe abused an adult with an intellectual or developmental disability. Nothing contained in 40.225 to 40.295 affects the duty to report imposed by this section of this rule, except that a psychiatrist, psychologist, clergy, or attorney is not required to report if the communication is privileged under 40.225 to 40.295.

(51) "Natural Supports" or "Natural Support System" means the resources available to an individual from the individual's relatives, friends, significant others, neighbors, roommates, and the community. Services provided by natural supports are resources that are not paid for by the Department.

(52) "Nurse" means a person who holds a current license from the Oregon Board of Nursing as a registered nurse or licensed practical nurse pursuant to ORS chapter 678.

(53) "Nursing Care Plan" means the plan of care developed by a registered nurse that describes the medical, nursing, psychosocial, and other needs of an individual and how those needs are met. The Nursing Care Plan includes the tasks that are taught, assigned, or delegated to a qualified provider or the individual's family.

(54) "Occupational Therapy" means the services described in OAR 411-330-0110 provided by a professional licensed under ORS 675.240 that are defined under the approved State Medicaid Plan, except that the amount, duration, and scope specified in the State Medicaid Plan do not apply.

(55) "Oregon Intervention System (OIS)" means the system of providing training to people who work with designated individuals to provide elements of positive behavior support and non-aversive behavior intervention. OIS uses principles of pro-active support and describes approved protective physical intervention techniques that are used to maintain health and safety.

(56) "OSIP-M" means Oregon Supplemental Income Program-Medical as defined in OAR 461-101-0010. OSIPM is Oregon Medicaid insurance coverage for individuals who meet eligibility criteria as described in OAR chapter 461.

(57) "Person-Centered Planning":

(a) Means a process, either formal or informal, for gathering and organizing information that helps an individual:

(A) Determine and describe choices about personal goals, activities, and lifestyle preferences;

(B) Design strategies and networks of support to achieve goals and a preferred lifestyle using individual strengths, relationships, and resources; and

(C) Identify, use, and strengthen naturally occurring opportunities for support at home and in the community.

(b) The methods for gathering information vary, but all are consistent with individual needs and preferences.

(58) "Personal Care Services" means assistance with activities of daily living, instrumental activities of daily living, and health-related tasks through cueing, monitoring, reassurance, redirection, set-up, hands-on, standby assistance, and reminding.

(59) "Personal Support Worker":

(a) Means a person:

(A) Who is hired by an individual with an intellectual or developmental disability or the individual's legal representative;

(B) Who receives money from the Department for the purpose of providing personal care services to the individual in the individual's home or community; and

(C) Whose compensation is provided in whole or in part through the Department or community developmental disability program.

(b) This definition of personal support worker is intended to reflect the term as defined in ORS 410.600.

(60) "Physical Therapy" means the services described in OAR 411-330-0110 provided by a professional licensed under ORS 688.020 that are defined under the State Medicaid Plan, except that the amount, duration, and scope specified in the State Medicaid Plan do not apply.

(61) "Positive Behavioral Theory and Practice" means a proactive approach to behavior and behavior interventions that:

(a) Emphasizes the development of functional alternative behavior and positive behavior intervention;

(b) Uses the least intervention possible;

(c) Ensures that abusive or demeaning interventions are never used; and

(d) Evaluates the effectiveness of behavior interventions based on objective data.

(62) "Prevocational Services" are services that are not job-task oriented that are aimed at preparing an individual with an intellectual or developmental disability for paid or unpaid employment. Prevocational services include teaching such concepts as compliance, attendance, task completion, problem solving, and safety. Prevocational services are provided to individuals not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year.

(63) "Productivity" as defined in ORS 427.005 means:

(a) Engagement in income-producing work by an individual that is measured through improvements in income level, employment status, or job advancement; or

(b) Engagement by an individual in work contributing to a household or community.

(64) "Provider" means a person, organization, or business selected by an individual with an intellectual or developmental disability or the individual's legal representative and paid with in-home support funds to provide support according to the individual's In-Home Support Plan.

(65) "Provider Organization" means an entity selected by an individual or the individual's legal representative, and paid with in-home support funds that:

(a) Is primarily in business to provide supports for individuals with intellectual or developmental disabilities;

(b) Provides supports for the individual through employees, contractors, or volunteers; and

(c) Receives compensation to recruit, supervise, and pay the persons who actually provide support for the individual.

(66) "Representative" means

(a) A person selected by an individual or the individual's legal representative to act on the individual's behalf to direct the individual's in-home support plan; and

(b) For the purposes of obtaining in-home support through an independent provider, the person selected by an individual or the individual's legal representative to act on the individual's behalf to provide the employer responsibilities described in OAR 411-330-0065.

(67) "Respite" means intermittent services as described in OAR 411-330-0110 provided on a periodic basis, but not more than 14 consecutive days, for the relief of, or due to the temporary absence of, a person normally providing supports to an individual with an intellectual or developmental disability unable to care for him or herself.

(68) "Services Coordinator" means an employee of the community developmental disability program or other agency that contracts with the county or Department, who is selected to plan, procure, coordinate, monitor Individual Support Plan services, and to act as a proponent for individuals with intellectual or developmental disabilities.

(69) "Skills Training" means activities intended to increase an individual's independence through training, coaching, and prompting the individual to accomplish activities of daily living, instrumental activities of daily living, and health-related skills.

(70) "Social Benefit" or "Social Service" means a service or financial assistance solely intended to assist an individual with an intellectual or developmental disability to function in society on a level comparable to that of a person who does not have an intellectual or developmental disability. Social benefits are pre-authorized by an individual's services coordinator and provided according to the description and financial limits written in an individual's In-Home Support (IHS) Plan.

(a) Social benefits may not:

(A) Duplicate benefits and services otherwise available to persons regardless of intellectual or developmental disability;

(B) Provide financial assistance with food, clothing, shelter, and laundry needs common to people with or without disabilities; or

(C) Replace other governmental or community services available to an individual.

(b) Financial assistance provided as a social benefit may not exceed the actual cost of the support required by an individual to be supported in the individual's home or in the family home and is either:

(A) Reimbursement for an expense previously authorized in an individual's IHS Plan; or

(B) An advance payment in anticipation of an expense authorized in a previously authorized IHS Plan.

(71) "Specialized Equipment and Supplies" mean devices, aids, controls, supplies, or appliances as described in OAR 411-330-0110 that meet applicable standards of manufacture, design, and installation that enable an individual to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. Specialized equipment and supplies do not include items not of direct benefit to an individual.

(72) "Speech, Hearing, and Language Services" mean the services as described in OAR 411-330-0110 provided by a professional licensed under ORS 681.250 that are defined under the approved State Medicaid Plan, except that the amount, duration, and scope specified in the State Medicaid Plan do not apply.

(73) "Substantiated" means an abuse investigation has been completed by the Department or the Department's designee and the preponderance of the evidence establishes the abuse occurred.

(74) "Support" means the assistance that an individual requires, solely because of the affects of an intellectual or developmental disability, to maintain or increase independence, achieve community presence and participation, and improve productivity. Support is subject to change with time and circumstances.

(75) "Supported Employment Services" provides supports for individuals for whom competitive employment is unlikely without ongoing support to perform in a work setting. Supported employment occurs in a variety of settings, particularly work sites in which people without disabilities are employed.

(76) "These Rules" mean the rules in OAR chapter 411, division 330.

(77) "Transition Costs" mean expenses such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility or intermediate care facility for the intellectually disabled to a community-based home setting where the individual resides.

(78) "Transportation" means services as described in OAR 411-330-0110 that allow individuals to gain access to community services, activities, and resources that are not medical in nature.

(79) "Unusual Incident" means any incident involving an individual that includes serious illness or accidents, death, injury or illness requiring inpatient or emergency hospitalization, suicide attempts, a fire requiring the services of a fire department, an act of physical aggression, or any incident requiring an abuse investigation.

(80) "Variance" means the temporary exception from a regulation or provision of these rules that may be granted by the Department, upon written application by the community developmental disability program.

(81) "Volunteer" means any person assisting a provider without pay to support the services provided to an individual.

Stat. Auth.: ORS 409.050 & 410.070
Stats. Implemented: ORS 427.005, 427.007 & 430.610 - 430.670
Hist.: SPD 21-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 8-2007(Temp), f. 6-27-07, cert. ef. 7-1-07 thru 12-28-07; SPD 20-2007, f. 12-27-07, cert. ef. 12-28-07; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 5-2010, f. 6-29-10, cert. ef. 7-1-10; SPD 9-2012(Temp), f. & cert. ef. 7-10-12 thru 1-6-13; SPD 1-2013, f. & cert. ef. 1-4-13; SPD 25-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-330-0030
Eligibility for In-Home Support Services

(1) NON-DISCRIMINATION. An eligible individual may not be denied in-home support services or otherwise discriminated against on the basis of age or of diagnostic or disability category. Access to service may not be restricted due to race, color, creed, national origin, citizenship, age, income, or duration of Oregon residence.

(2) ELIGIBILITY PRIOR TO JULY 1, 2013. Prior to July 1, 2013, an individual is eligible for in-home support services when:

(a) The individual has been determined eligible for developmental disability services by the CDDP of the individual's county of residence; and

(b) The individual is an adult living at home or in the family home whose in-home support services or combined in-home support services and employment and alternatives to employment services regulated by OAR chapter 411, division 345 cost more than $21,119 per year plus application of any subsequent legislatively-approved cost-of-living increments; and

(c) Part or all of the funds to support the individual have been designated by contract with the CDDP because:

(A) The Department has determined the individual is at imminent risk of civil commitment under ORS 427 and the Department is providing diversion services according to the provisions of OAR 411-320-0160; or

(B) Funds previously used to purchase the individual's Department-regulated residential, work, or day habilitation services have been made available within the guidelines published by the Department to purchase in-home services that cost more than $21,119 per year plus application of any subsequent legislatively-approved cost-of-living increments; or

(C) The Department has found the individual eligible for Comprehensive 300 services as defined through the settlement agreement Staley v. Kitzhaber (USDC CV00-0078-ST) and has made funds available to purchase in-home services that cost more than $21,119 per year plus application of any subsequent legislatively-approved cost-of-living increments.

(3) ELIGIBILITY ON OR AFTER JULY 1, 2013. An individual who enters in-home support services on or after July 1, 2013, is subject to eligibility as described in this section.

(a) To be eligible for home and community-based waivered services or Community First Choice state plan services, an individual must:

(A) Be an Oregon resident;

(B) Be eligible for OSIP-M;

(C) Be determined eligible for developmental disability services by the CDDP of the individual's county of residence as described in OAR 411-320-0080; and

(D) After completion of an assessment, meet the level of care defined in OAR 411-330-0020.

(b) To be eligible for in-home support services, an individual must:

(A) Be an Oregon resident;

(B) Be determined eligible for developmental disability services by the CDDP of the individual's county of residence as described in OAR 411-320-0080;

(C) Be an adult who is living in his or her own home or the family home who is not receiving other Department-funded in-home or community living support;

(D) Choose to use a CDDP for assistance with design and management of in-home support services; and

(E) Be eligible for home and community-based waivered services or Community First Choice state plan services as described in subsection (a) of this section; or

(F) Be determined to meet crisis eligibility as defined in OAR 411-320-0160; or

(G) Up to an individual's 18th birthday, be enrolled in the Children's Intensive In-home Services (CIIS) Program as described in OAR chapter 411, division 300 or Long Term Supports as described in OAR chapter 411, division 308.

(4) CONCURRENT ELIGIBILITY. An individual may not be found eligible for in-home support services by more than one CDDP unless the concurrent eligibility is necessary to effect transition from one county to another with a change of residence and is part of a collaborative plan developed by both CDDPs in which services and expenditures authorized by one CDDP are not duplicated by the other CDDP.

Stat. Auth.: ORS 409.050 & 410.070
Stats. Implemented: ORS 427.005, 427.007, 430.610 - 430.670
Hist.: SPD 21-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 8-2007(Temp), f. 6-27-07, cert. ef. 7-1-07 thru 12-28-07; SPD 20-2007, f. 12-27-07, cert. ef. 12-28-07; SPD 25-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-330-0040
Service Entry and Exit

(1) The CDDP must make accurate, up-to-date written information about in-home support services available to eligible individuals and the individual's representative that includes --

(a) Criteria for entry, conditions for exit, and how the limits of assistance with purchasing supports are determined;

(b) A description of processes involved in using in-home support services, including person-centered planning, evaluation, and how to raise and resolve concerns about in-home support services;

(c) Clarification of CDDP employee responsibilities as mandatory abuse reporters;

(d) A brief description of individual and legal representative responsibility for use of public funds; and

(e) An explanation of individual rights to select and direct providers of services authorized through the individual's IHS Plan and purchased with IHS funds from among those qualified according to OAR 411-330-0070, 411-330-0080, or 411-330-0090.

(2) The CDDP must make information required in section (1) of this rule available using language, format, and presentation methods appropriate for effective communication according to individual needs and abilities.

(3) ENTRY. An individual enters in-home support services when funds are made available through a Department contract with the CDDP specifically to support the individual.

(4) DURATION. An eligible individual who has entered a CDDP's in-home support service may continue to receive in-home support services as long as the Department continues to provide funds specifically for that individual through contract with the CDDP and the individual continues to require the services to remain at home or in the family home.

(5) EXIT. An individual must exit in-home support services:

(a) At the end of a service period agreed upon by all parties and specified in the individual's IHS Plan;

(b) No less than 30 days after the CDDP has served an individual or the individual's legal representative written notice of intent to terminate services when the individual has been determined to no longer meet eligibility for in-home support services as described in OAR 411-330-0030, except when the individual appeals notice of intent to terminate services and requests continuing services in accordance with ORS 183;

(c) At the written request of an individual or the individual's legal representative to end the service relationship;

(d) When an individual moves from a CDDP's service area, unless services are part of a time-limited plan for transition to a new county of residence;

(e) When funds to support an individual are no longer provided through the Department contract to the CDDP of the individual's county of residence;

(f) When a CDDP has sufficient evidence to believe that an individual or the individual's legal representative has engaged in fraud or misrepresentation, failed to use resources as agreed upon in the IHS Plan, refused to cooperate with documenting expenses, or otherwise knowingly misused public funds associated with these services; or

(g) No less than 30 days after a CDDP has served written notice of intent to terminate services, when an individual or the individual's legal representative either cannot be located or has not responded to repeated attempts by CDDP staff to complete plan development and monitoring activities and, further, does not respond to the notice of intent to terminate.

Stat. Auth.: ORS 410.070 & 409.050
Stats. Implemented: ORS 430.610 - 430.670 427.005 - 427.007
Hist.: SPD 21-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 25-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-330-0050
Required In-Home Support Services

(1) Each CDDP must provide or arrange for the following services as required to meet the support needs of eligible individuals:

(a) Assistance to determine needs and plan supports;

(b) Assistance to find and arrange resources and supports;

(c) Education and technical assistance to make informed decisions about support needs and direct support providers;

(d) Fiscal intermediary services;

(e) Employer-related supports; and

(f) Assistance to monitor and improve the quality of personal supports.

(2) A CDDP must complete an FNAT using a person-centered planning approach to assist an individual and the individual's legal representative to establish outcomes, determine needs, plan for supports, and review and redesign support strategies. The planning process must address the individual's basic health and safety needs and supports, including informed decisions by the individual or the individual's legal representative regarding any identified risks.

(3) IN-HOME SUPPORT PLAN. An individual's services coordinator must write an initial IHS Plan that addresses the individual's needs identified in the FNAT. The IHS Plan must be signed by the individual (or the individual's representative) prior to services beginning. The IHS Plan and attached documents must include:

(a) The individual's name and, if applicable, the name of the individual's legal representative;

(b) The purpose of IHS Plan activities, addressing one or more of the following:

(A) Independence, i.e. the degree of choice and control an individual hopes to achieve or maintain;

(B) Integration, i.e. the regular access to relationships and community resources the individual hopes to achieve or maintain;

(C) Productivity, i.e. the employment or other contributing roles an individual hopes to achieve or maintain; or

(D) Developing or maintaining the capacity of an individual's family to continue to provide services for the individual in the family home.

(c) A description of the supports required to accomplish the purpose, with a brief statement of the nature of the individual's disability that makes the support necessary. For an initial or annual IHS Plan that is authorized on or after October 1, 2013, the description must be consistent with the FNAT;

(d) Projected dates of when specific supports are to begin and end, as well as the end date, if any, of the period of service covered by the IHS Plan;

(e) For an initial or annual IHS Plan that is authorized prior to October 1, 2013, projected costs, with sufficient detail to support estimates;

(f) A list of personal, community, and public resources that are available to the individual and how the resources may be applied to provide the required supports. Sources of support may include waivered or state plan services, state general funds, or natural supports.

(g) For an initial or annual IHS Plan that is authorized prior to October 1, 2013, final IHS fund costs;

(h) Schedule of plan reviews; and

(i) For an initial or annual IHS Plan that is authorized after October 1, 2013, the IHS Plan must reflect any changes in support needs identified on a FNAT.

(4) NURSING CARE PLAN. A Nursing Care Plan must be included in the IHS planning when IHS funds are used to purchase care and services requiring the education and training of a licensed professional nurse.

(5) REVIEW. An individual's services coordinator must conduct and document reviews of the individual's IHS Plan and resources with the individual and the individual's legal representative as follows:

(a) At least quarterly, to review and reconcile receipts and records related to purchases of supports with IHS funds;

(b) At least annually and as major activities or purchases are completed:

(A) Evaluate progress toward achieving the purposes of the IHS Plan;

(B) Note effectiveness of purchases based on the services coordinator's observation as well as the individual's or the individual's legal representative's satisfaction; and

(C) Determine whether changing needs or availability of other resources has altered the need for continued use of IHS funds to purchase supports.

(6) TRANSITION. For an individual moving to another service area within Oregon, the CDDP must collaborate with the receiving CDDP to transfer IHS funds designated for the individual to continue the individual's IHS Plan for supports.

Stat. Auth.: ORS 410.070 & 409.050
Stats. Implemented: ORS 430.610 - 430.670 & 427.005 - 427.007
Hist.: SPD 21-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 25-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-330-0060
In-Home Support Fund Assistance with Purchasing Supports

(1) A CDDP must only use IHS funds to assist an individual and the individual's legal representative to purchase supports when the individual's services coordinator has developed a written and approved IHS Plan that meets requirements for development and content as described in OAR 411-330-0050 and:

(a) For plans authorized for implementation on or after October 1, 2013, an FNAT has identified supports that are necessary for the individual to live in the individual's own home or in the family home;

(b) The IHS Plan specifies cost-effective arrangements for obtaining the required supports and applying public, private, formal, and informal resources available to the eligible individual;

(c) The IHS Plan identifies the resources needed to purchase the remainder of necessary supports; and

(d) The IHS Plan is the most cost-effective plan that safely meets the goals of the IHS Plan.

(2) Goods and services purchased with IHS funds must be provided only as a social benefit as defined in OAR 411-330-0020.

(3) The method, amount, and schedule of payment must be specified in written agreements between the CDDP and the individual and the individual's legal representative, if any. The CDDP is specifically prohibited from:

(a) Reimbursement of an individual or the individual's legal representative or family for expenses related to services; and

(b) Advancing funds to an individual or the individual's legal representative or family to obtain services.

(4) Supports purchased for an individual with IHS funds are limited to those described in OAR 411-330-0110. The CDDP must arrange for these supports to be provided:

(a) In settings and under contractual conditions that provide the individual or the individual's legal representative the choice to receive supports and services from another provider;

(b) In a manner consistent with positive behavioral theory and practice as defined in OAR 411-330-0020;

(c) In accordance with applicable state and federal wage and hour regulations in the case of personal care, training, and supervision;

(d) In accordance with applicable state or local building codes, in the case of environmental accessibility adaptations to the home; and

(e) According to the Oregon Board of Nursing rules in OAR chapter 851 when services involve performance of nursing care or delegation, teaching, and assignment of nursing tasks.

(5) When IHS funds are used to purchase supports for individuals, the CDDP must require and document that providers are informed of:

(a) Mandatory responsibility to report suspected abuse of an adult;

(b) Responsibility to immediately notify an individual's legal representative and family (if services are provided to an individual in the family home) and the CDDP of injury, illness, accidents, or any unusual circumstances that may have a serious effect on the health, safety, physical, emotional well being, or level of services required by the individual for whom services are being provided; and

(c) Limits of payment:

(A) IHS fund payments for the agreed-upon services must be considered full payment and the provider under no circumstances may demand or receive additional payment for these services from the individual, the individual's legal representative, or the individual's family, or any other source.

(B) The provider must bill all third party resources before using IHS funds unless another arrangement is agreed upon by the CDDP in the IHS Plan.

(6) USE OF IHS FUNDS PROHIBITED.

(a) Effective July 28, 2009, IHS funds may not be used to support, in whole or in part, a provider in any capacity who has been convicted of any of the disqualifying crimes listed in OAR 407-007-0275.

(b) Section (6)(a) of this rule does not apply to employees of the individual or the individual's legal representative, or employees of provider organizations who were hired prior to July 28, 2009 and remain in the current position for which the employee was hired.

(c) IHS funds shall not pay for:

(A) Services, materials, or activities that are illegal;

(B) Services or activities that are carried out in a manner that constitutes abuse as defined in OAR 411-330-0020;

(C) Materials or equipment that has been determined unsafe for the general public by recognized consumer safety agencies;

(D) Individual or family vehicles;

(E) Health and medical costs that the general public normally must pay including but not limited to:

(i) Medications;

(ii) Health insurance co-payments;

(iii) Mental health evaluation and treatment;

(iv) Dental treatments and appliances;

(v) Medical treatments;

(vi) Dietary supplements; or

(vii) Treatment supplies not related to nutrition, incontinence, or infection control;

(F) Basic or specialized food or nutrition essential to sustain the individual including but not limited to high caloric supplements, gluten-free supplements, diabetic, ketogenic, or other metabolic supplements.

(G) Ambulance services;

(H) Legal fees including but not limited to costs of representation in educational negotiations, establishing trusts, or creating guardianships;

(I) Vacation costs for transportation, food, shelter, and entertainment that are normally incurred by a person on vacation, regardless of disability, and are not strictly required by the individual's need for personal assistance in all home and community-based settings;

(J) Individual support that has not been arranged according to applicable state and federal wage and hour regulations;

(K) Rate enhancements to an individual's existing employment and alternative to employment services for individuals with developmental disabilities under OAR chapter 411, division 345;

(L) Employee wages or contractor payments for services when the individual is not present or available to receive services (e.g. employee paid time off, hourly "no-show" charges, and contractor preparation hours);

(M) Services, activities, materials, or equipment that are not necessary or cost-effective, and do not meet the definition of in-home supports, supports, and social benefits, as defined in OAR 411-330-0020;

(N) Educational services for school-age adults, including professional instruction, formal training, and tutoring in communication, socialization, and academic skills;

(O) Services, activities, materials, or equipment that may be obtained by the individual or the individual's legal representative through other available means such as private or public insurance, philanthropic organizations, or other governmental or public services;

(P) Services or activities for which the legislative or executive branch of Oregon government has prohibited use of public funds; or

(Q) Service in circumstances where the CDDP determines there is sufficient evidence to believe that the individual, the individual's legal representative, family, or service provider has engaged in fraud or misrepresentation, failed to use resources as agreed upon in the IHS Plan, refused to cooperate with record keeping required to document use of IHS funds, or otherwise knowingly misused public funds associated with IHS services.

(7) The CDDP must inform an individual and the individual's legal representative in writing of records and procedures required in OAR 411-330-0140 regarding expenditure of IHS funds for direct assistance. During development of the IHS Plan, the individual's services coordinator must determine the need or preference for the CDDP to provide support with documentation and procedural requirements and must include delineations of responsibility for maintenance of records in the IHS Plan and any other written service agreements.

Stat. Auth.: ORS 410.070 & 409.050

Stats. Implemented: ORS 427.005, 427.007 & 430.610 - 430.670

Hist.: SPD 21-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 2-2010(Temp), f. & cert. ef. 3-18-10 thru 6-30-10; SPD 5-2010, f. 6-29-10, cert. ef. 7-1-10; SPD 25-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-330-0070

Standards for Independent Providers Paid with In-Home Support Services Funds

(1) GENERAL INDEPENDENT PROVIDER QUALIFICATIONS. Each independent provider who is paid as a contractor, a self-employed person, or an employee of an individual or the individual's representative must:

(a) Be at least 18 years of age;

(b) Have approval to work based on a background check completed by the Department in accordance with OAR 407-007-0200 to 407-007-0370. A subject individual as defined in 407-007-0210 may be approved for one position to work in multiple homes within the jurisdiction of the qualified entity as defined in 407-007-0210. The Department's Background Check Request Form must be completed by the subject individual to show intent to work at various homes;

(c) Effective July 28, 2009, not have been convicted of any of the disqualifying crimes listed in OAR 407-007-0275:

(d) Be legally eligible to work in the United States;

(e) Not be the spouse of the individual receiving services;

(f) Demonstrate by background, education, references, skills, and abilities that he or she is capable of safely and adequately performing the tasks specified on the individual's IHS Plan, with such demonstration confirmed in writing by the employing individual or the individual's representative, family, or designated advocate including:

(A) Ability and sufficient education to follow oral and written instructions and keep any records required;

(B) Responsibility, maturity, and reputable character exercising sound judgment;

(C) Ability to communicate with the individual; and

(D) Training of a nature and type sufficient to ensure that the provider has knowledge of emergency procedures specific to the individual being cared for;

(g) Hold current, valid, and unrestricted appropriate professional license or certification where care and supervision requires specific professional education, training, and skill;

(h) Understand requirements of maintaining confidentiality and safeguarding individual information;

(i) Not be on the Office of Inspector General's list of excluded or debarred providers (http://exclusions.oig.hhs.gov/);

(j) In the case of an agency, hold any license or certificate required by the state of Oregon or federal law or regulation to provide the services purchased by or for the individual; and

(k) If providing transportation, have a valid driver's license and proof of insurance, as well as other license or certificate that may be required under state and local law, depending on the nature and scope of the transportation service.

(2) Section (1)(c) of this rule does not apply to employees of an individual or the individual's legal representative or employees of provider organizations who were hired prior to July 28, 2009 and remain in the current position for which the employee was hired.

(3) All providers must self-report any potentially disqualifying condition as described in OAR 407-007-0280 and OAR 407-007-0290. The provider must notify the Department or the Department's designee within 24 hours.

(4) BEHAVIOR CONSULTANTS. Behavior consultants providing specialized supports must:

(a) Have education, skills, and abilities necessary to provide behavior consultation services, including knowledge and experience in developing plans based on positive behavioral theory and practice;

(b) Have received at least two days of training in OIS and have a current certificate; and

(c) Submit a resume to the CDDP indicating at least one of the following:

(A) A bachelor's degree in special education, psychology, speech and communication, occupational therapy, recreation, art or music therapy, or a behavioral science field and at least one year of experience with individuals who present difficult or dangerous behaviors; or

(B) Three years experience with individuals who present difficult or dangerous behaviors and at least one year of that experience must include providing the services of a behavior consultant.

(5) NURSE. A nurse providing community nursing services must:

(a) Have a current Oregon nursing license; and

(b) Submit a resume to the CDDP indicating the education, skills, and abilities necessary to provide nursing services in accordance with Oregon law, including at least one year of experience with individuals with developmental disabilities.

(6) FAMILY TRAINING PROVIDERS. Providers of family training must be:

(a) Psychologists licensed under ORS 675.030;

(b) Social workers licensed under ORS 675.530;

(c) Counselors licensed under ORS 675.715; or

(d) Medical professionals licensed under ORS 677.100.

Stat. Auth.: ORS 410.070 & 409.050

Stats. Implemented: ORS 427.005, 427.007 & 430.610 - 430.670

Hist.: SPD 21-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 2-2010(Temp), f. & cert. ef. 3-18-10 thru 6-30-10; SPD 5-2010, f. 6-29-10, cert. ef. 7-1-10; SPD 25-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-330-0080

Standards for Provider Organizations Paid with In-Home Support Services Funds

(1) A provider organization licensed under OAR chapter 411, division 325 for 24-hour residential services or OAR chapter 411, division 360 for adult foster homes or certified under OAR chapter 411, division 345 for employment and alternatives to employment services, OAR chapter 411, division 328 for supported living services, or OAR chapter 411, division 340 for support services do not require additional certification as an organization to provide respite, supported employment, community living, community inclusion, emergent services, or support services.

(2) Current license or certification is considered sufficient demonstration of ability to:

(a) Recruit, hire, supervise, and train qualified staff;

(b) Provide services according to IHS Plans; and

(c) Develop and implement operating policies and procedures required for managing an organization and delivering services, including provisions for safeguarding individuals receiving services.

(3) All persons directed by the provider organization as employees, contractors, or volunteers to provide services paid for with IHS funds must meet standards for qualification of independent providers outlined in OAR 411-330-0070.

Stat. Auth.: ORS 410.070 & 409.050

Stats. Implemented: ORS 430.610 - 430.670 & 427.005 - 427.007

Hist.: SPD 21-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 25-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-330-0090

Standards for General Business Providers

(1) General business providers providing services to individuals and paid with IHS funds must hold any current license appropriate to function required by the State of Oregon or federal law or regulation, including but not limited to:

(a) For a home health agency, a license under ORS 443.015;

(b) For an in-home care agency, a license under ORS 443.315;

(c) For providers of environmental accessibility adaptations involving building modifications or new construction, a current license and bond as a building contractor as required by OAR chapter 812 (Construction Contractor's Board) and OAR chapter 808 (Landscape Contractors);

(d) For environmental accessibility consultants, a current license as a general contractor as required by OAR chapter 812 including experience evaluating homes, assessing the needs of an individual, and developing cost-effective plans to make homes safe and accessible;

(e) For public transportation providers, the established standards and for private transportation providers, a business license and drivers licensed to drive in Oregon; and

(f) For vendors and medical supply companies providing specialized medical equipment and supplies, a current retail business license including enrollment as Medicaid providers through the Oregon Health Authority's Division of Medical Assistance Programs if vending medical equipment.

(2) Services provided and paid for with IHS funds are limited to the services within the scope of the general business provider's license.

Stat. Auth.: ORS 410.070 & 409.050

Stats. Implemented: ORS 430.610 - 430.670 & 427.005 - 427.007

Hist.: SPD 21-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 25-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-330-0110

Supports Purchased with In-Home Funds

(1) For IHS Plans authorized prior to July 1, 2013, when the conditions of purchase in OAR 411-330-0060 are met, IHS funds may be used to purchase:

(a) Behavior Consultation. Behavior consultation consists of: assessment of the individual, the needs of the family and the environment; development of positive behavior support strategies including a behavior support plan if needed; implementation of the positive behavior support plan with the provider or family; and revision and monitoring of the plan as needed. Services may include training, modeling, and mentoring the family, development of visual communication systems as behavior support strategies, and communicating as authorized by the individual or their legal representative with school, medical or other professionals about the strategies and outcomes of the behavior support plan.

(A) Providers may include, but are not limited to, licensed psychologists, behavioral specialists, autism specialists, or other communication specialists who meet the requirements in OAR 411-330-0070(1)(a) through (j) and (2)(a) through (c).

(B) Behavior consultation does not include: mental health therapy or counseling; health or mental health plan coverage; educational services, including, but not limited to, consultation and training for classroom staff, adaptations to meet needs of the individual at school, assessment in the school setting, or any service identified by the school as required to carry out the person's Individual Education Plan.

(b) Community inclusion services. Community inclusion services assist an individual to acquire, retain or improve physical or mental skills, which enhance integration, independence and/or productivity and take place separate from the home in which the individual lives and occur on a regularly scheduled basis. Community Inclusion Supports include assistance to participate in generic community services, facilities, businesses, recreation and leisure. These supports are provided for an individual to participate in activities to facilitate independence and promote community inclusion in settings chosen by the individual and the individual's legal representative.

(A) Community inclusion services include, but are not limited to: assistance in use of community resources (e.g. shopping, transportation systems; personal assistance to attend local interest clubs, gym or sports events; assistance to build relationships with non-disabled individuals in community settings capable of providing natural support; opportunities for activities and socialization with other people with disabilities; and/or assistance with eating, toileting, mobility during recreational activities); and the cost of daily care and supervision.

(B) Examples of what community inclusion services do not provide include, but are not limited to: fees for attending local clubs, gyms or sporting events; secondary and post-secondary education services; tuition to private schools; services provided by a spouse of the individual; illegal activities; legal fees; vacation costs that would normally be incurred by anyone on vacation regardless of disability; supports that have not been arranged according to applicable state and federal wage and hour regulations; services that are not necessary or cost-effective; and services or activities carried out in a manner that constitutes abuse of an adult.

(c) Supported employment services. Supported employment services assist an individual to choose, get and keep a paid job in an integrated community business setting.

(A) Supported employment services include job development, training and on-going supervision to obtain paid employment. Training may

focus on the individual worker and co-workers without disabilities capable of providing natural support.

(B) Examples of what supported employment services do not provide include, but are not limited to the following: support provided by someone who does not meet the minimum independent provider qualifications as specified in OAR 411-330-0070; illegal activities; legal fees; services or activities carried out in a manner that constitutes abuse of an adult; care, training, or supervision that has not been arranged according to applicable state and federal wage and hour regulations; rate enhancements to an individual's existing employment/community inclusion service under 309-047-0000 through 309-047-0140; payment for the supervisory activities rendered as a normal part of the business setting; incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; payments for vocational training that is not directly related to an individual's supported employment program; and services that are not necessary or cost-effective. For purposes of this rule:

(i) Supported employment services must not replace services available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

(ii) Supported employment services under this rule must not replace or duplicate services that the individual currently receives through the Department-contracted Employment and Alternative to Employment Services governed by OAR 411-345-0010 through 411-345-0310.

(d) Environmental Accessibility Adaptations. Environmental accessibility adaptations are physical adaptations to an individual's home, which are necessary to ensure the health, welfare, and safety of the individual in the home, or which enable the individual to function with greater independence around the home.

(A) Examples of environmental accessibility adaptations include, but are not limited to: environmental modification consultation to determine the appropriate type of adaptation; installation of ramps and grab-bars; removing or widening of doorways; handrails; electric door openers; adaptations of kitchen cabinet/sinks; modifications of bathroom facilities; hardening the environment; protective fencing; individual room air conditioners to maintain stable temperature as required by the individual's medical condition; overhead track systems to assist with lifting or transferring of individuals; installation of specialized electric and plumbing systems which are necessary to accommodate medical equipment; and supplies necessary for the welfare of the individual.

(B) Examples of what environmental accessibility supports do not provide include, but are not limited to: generic fire safety equipment; generic household maintenance and repair; adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, adaptations or improvements to the home which add to the total square footage of the home; adaptations and modifications not constructed in accordance with applicable State or local codes; adaptations and improvements not necessary or cost-effective; and materials or equipment that have been determined unsafe for the general public by recognized consumer safety agencies.

(C) Environmental modification consultants must be licensed general contractors and have experience evaluating homes, assessing the needs of the individual and developing cost-effective plans to make homes safe and accessible.

(D) Providers of environmental accessibility adaptation involving building modifications or new construction must be building contractors licensed under OAR 812-001-0000 through 812-010-0500 and 808-001-0000 through 808-005-0030.

(e) Family Caregiver Supports. Family caregiver services assist families with unusual responsibilities of planning and managing provider services for the individual. These services are fiscal intermediary services to pay vendors and to carry out payroll and reporting functions when providers are domestic employees of the family.

(f) Family Training. Family training services are training and counseling services provided to the family of an individual with developmental disabilities to increase their capabilities to care for, support and maintain the individual in the home.

(A) Family training services include, but are not limited to: instruction about treatment regimens and use of equipment specified in the In-Home Support Plan; information, education and training about the individual's disability, medical, and behavioral conditions. Family training services may be provided in various settings by various means, including but not limited to: psychologists licensed under ORS 675.030; professionals licensed to practice medicine under 677.100 or nursing under 678.040; social workers licensed under 675.530; counselors licensed under 675.715; organized conferences and workshops specifically related to the individual's disability, identified support needs, or specialized medical or behavioral support needs.

(B) Examples of what family training services do not provide include, but are not limited to: mental health counseling, treatment, or therapy; training for paid caregivers; legal fees; training for families to carry out educational activities in lieu of school; vocational training for family members; and paying for training to carry out activities that constitute abuse of an adult.

(C) Prior authorization by the CDDP is required for attendance by family members at organized conferences and workshops funded with In-Home Support Services funds.

(g) In-Home Support. In-Home Support services are care, training, supervision and protection provided based on the needs of the individual that must be met for the individual to live in the family home.

(A) In-Home Support services include, but are not limited to: providers who come into the family home and assist the individual with: activities of daily living; medical and physical health care including performance or delegation of nursing tasks; behavior management; maintenance of expressive and receptive skills in verbal and non-verbal language; functional application of acquired reading and writing skills; training and support in personal environmental skills such as planning and preparing meals, budgeting, laundry, and housecleaning.

(B) Examples of what In-Home Support services do not provide include, but are not limited to: services provided by the spouse of the individual; services available through private insurance or health plan; services provided by someone who does not meet the minimum provider qualifications of this rule; behavior management not based on positive behavioral theory and practice; legal fees; care, training or supervision that has not been arranged according to applicable state and federal wage and hour regulations; health and medical costs that the general public normally must pay; educational services for school-age individuals; and replacing support normally provided to the individual by a family member. For individuals who live in the family home, family members are expected to provide a minimum of 8 hours of support daily with the exception of respite.

(h) Occupational Therapy. Occupational therapy services are the services of a professional licensed under ORS 675.240 that are defined and approved for purchase under the approved State Medicaid Plan, except that the limitation on amount, duration and scope in the plan will not apply. These services are available to maintain an individual's skills or physical condition when prescribed by a physician and after the service limits of the State Medicaid Plan have been reached, either through private or public resources.

(A) Occupational therapy services include assessment, family training, consultation, and hands-on direct therapy provided by an appropriately licensed or certified occupational therapist when there is written proof that the Oregon Health Plan service limits have been reached.

(B) Occupational therapy services do not include: goods and services available through either public programs (e.g. OHP, schools, or Federal assistance programs) for which an individual is eligible, or through an individual's private insurance; experimental therapy or treatments; health and medical costs that the general public must pay; legal fees; and education services for an individual such as tuition to schools.

(i) Physical Therapy. Physical therapy services are the services of a professional licensed under ORS 688.020 that are defined and approved for purchase under the approved State Medicaid Plan, except that the limitation on amount, duration and scope in the plan will not apply. These services are available to maintain an individual's skills or physical condition when prescribed by a physician and after the service limits of the State Medicaid Plan have been reached, either through private or public resources.

(A) Physical therapy services include assessment, family training, consultation, and hands-on direct therapy provided by an appropriately licensed or certified physical therapist when there is written proof that the Oregon Health Plan service limits have been reached.

(B) Physical therapy services do not include: goods and services available through either public programs (e.g. OHP, schools, or Federal assistance programs) for which an individual is eligible, or through an individual's private insurance; experimental therapy or treatments; health and medical costs that the general public must pay; legal fees; and education services for an individual such as tuition to schools.

(j) Respite Care. Respite care services are short-term care provided on an hourly or daily basis because of the absence, or need for relief of, persons normally providing the care to an individual with developmental disabilities.

(A) Temporary or overnight respite services may be provided in a variety of settings, including, but not limited to: the home of the individual; a licensed group home or foster home; a licensed day care center; or a community care facility that is not a private residence.

(B) Respite services do not include: ongoing services which occur on a regular schedule such as 8-hours-a-day, 5-days-a-week or are provided to allow the individual's family to attend school or work; vacation travel and lodging expenses; cost of the individual's meals unless part of a short-term stay in a licensed facility, group home or foster home.

(k) Specialized Equipment and Supplies. Specialized equipment and supplies are devices, controls, or appliances specified in the In-Home Support Plan, which enable an individual to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment permitted under the Medicaid State Plan after the scope and limits of the State Medicaid Plan have been reached.

(A) Examples of specialized equipment and supplies include, but are not limited to: mobility, communication, incontinence, and positioning devices; age-appropriate hospital beds; continuous positioning airway pressure, apnea monitors; generators for technology-dependent individuals; equipment required to obtain urgent medical assistance; a manual wheelchair to use while power chair is being repaired; a second wheelchair that can fit into interior doors while larger power chair remains outside; latex gloves and similar supplies used in personal care; and equipment such as plates, bowls, utensils, glasses, trays that allow an individual to eat independently or with minimum assistance

(B) Examples of items that are not Specialized Equipment and Supplies include, but are not limited to: work-related clothing; generic household furnishings; personal clothing for the individual or family, and other purchases made because of financial need; any equipment or supplies that can be purchased by the individual through the Oregon Health Plan or private insurance, or obtained through other resources; illegal substances or materials; materials or equipment that have been determined unsafe for the general public by recognized consumer safety agencies; items which are needed solely to allow an individual to participate in school; items not of direct medical or remedial benefit to the individual; and equipment that is not necessary or cost-effective, experimental, not generally-accepted, or absolutely prohibited by the Oregon Health Plan.

(l) Speech, Hearing, and Language Services. Speech, hearing and language services are the services of a professional licensed under ORS 681.250 that are defined and approved for purchase under the approved State Medicaid Plan, except that the limitation on amount, duration and scope specified in the plan will not apply. These services are available to maintain an individual's skills or physical condition when prescribed by a physician and after the service limits of the State Medicaid Plan have been reached, either through private or public resources.

(A) Speech, hearing, and language services include assessment, family training, consultation, and hands-on direct therapy provided by an appropriately licensed or certified speech therapy professional when there is written proof that the Oregon Health Plan service limits have been reached.

(B) Speech, hearing, and language services do not include: goods and services available through either public programs (e.g. OHP, schools, or Federal assistance programs) for which an individual is eligible, or through an individual's private insurance; experimental therapy or treatments; health and medical costs that the general public must pay; legal fees; and education services for an individual such as tuition to schools. Educational services for school age individuals, such as: professional instruction, formal training, and tutoring in communication, socialization, and academic skills are not allowable expenses covered by In-Home Support Services funds.

(m) Transportation services. Transportation services are services that provide training or support in public or private transportation required for the individual to attend recreation, day programs, appointments, and related services according to an In-Home Support Plan.

(A) Transportation services include, but are not limited to: transportation provided by common carriers, taxicab or bus in accordance with standards established for these entities; reimbursement on a per-mile basis for transporting an individual in a rural area into the nearest town once a week for shopping and recreational opportunities; assistance with purchase of a bus pass; and reimbursement of operational expenses of agency/staff vehicles used for transporting individuals not to exceed established rates.

(B) Transportation services do not include: medical transportation; purchase of individual or family vehicles; routine vehicle maintenance and repair; ambulance services; payment to a spouse of an individual recipient of In-Home Support services; costs for transporting someone other than the individual with disabilities.

(2) For an initial or annual IHS Plan that is authorized on or after July 1, 2013, IHS funds may be used to purchase the following when the conditions of purchase in OAR 411-330-0060 are met:

(a) Community First Choice state plan services:

(A) Community nursing services as described in section (3) of this rule;

(B) Chore services as described in section (4) of this rule;

(C) Personal care as described in section (5) of this rule;

(D) Skills training as described in section (6) of this rule;

(E) Transportation as described in section (7) of this rule;

(F) Specialized medical equipment and supplies as described in section (8) of this rule;

(G) Respite as described in section (9) of this rule;

(H) Behavior support services as described in section (10) of this rule;

(I) Environmental accessibility adaptations as described in section (11) of this rule; and

(J) Transition costs as described in section (12) of this rule.

(b) Home and Community Based Waiver Services:

(A) Alternatives to employment - habilitation as described in section (13) of this rule;

(B) Pre-vocational services as described in section (14) of this rule;

(C) Supported employment as described in section (15) of this rule;

(D) Family training as described in section (16) of this rule;

(E) Occupational therapy as described in section (17) of this rule;

(F) Physical therapy as described in section (18) of this rule; and

(G) Speech, hearing, and language services as described in section (19) of this rule.

(3) COMMUNITY NURSING SERVICES. Community nursing services includes:

(a) Evaluation and identification of supports that minimize health risks while promoting an individual's autonomy and self-management of healthcare;

(b) Medication reviews;

(c) Collateral contact with a services coordinator regarding an individual's community health status to assist in monitoring safety and well-being and to address needed changes to the person-centered Individual Support Plan; and

(d) Delegation of nursing tasks to an individual's provider so the provider may safely perform health related tasks.

(4) CHORE SERVICES. Chore services may be provided only in situations where no one else in the home is capable of either performing or paying for the services and no other relative, caregiver, landlord, community, volunteer. agency, or third-party payer is capable of, or responsible for, providing these services;

(5) PERSONAL CARE SERVICES (ADL/IADL).

(a) Personal care services include but are not limited to:

(A) Basic personal hygiene — providing or assisting an individual with such needs as bathing (tub, bed, bath, shower), washing hair, grooming, shaving, nail care, foot care, dressing, skin care, mouth care, and oral hygiene;

(B) Toileting, bowel, and bladder care — assisting an individual to and from bathroom, on and off toilet, commode, bedpan, urinal, or other assistive device used for toileting, changing incontinence supplies, following a toileting schedule, cleansing an individual or adjusting clothing related to toileting, emptying catheter drainage bag or assistive device, ostomy care, or bowel care;

(C) Mobility, transfers, and repositioning — assisting an individual with ambulation or transfers with or without assistive devices, turning the individual or adjusting padding for physical comfort or pressure relief, or encouraging or assisting with range-of-motion exercises;

(D) Nutrition — preparing meals and special diets, assisting an individual with adequate fluid intake or adequate nutrition, assisting with food intake (feeding), monitoring to prevent choking or aspiration, assisting with special utensils, cutting food, and placing food, dishes, and utensils within reach for eating;

(E) Medication and oxygen management — assisting with ordering, organizing, and administering oxygen or prescribed medications (including pills, drops, ointments, creams, injections, inhalers, and suppositories), monitoring an individual for choking while taking medications, assisting with the administration of oxygen, maintaining clean oxygen equipment, and monitoring for adequate oxygen supply;

(F) Delegated nursing tasks;

(G) Housekeeping — tasks necessary to maintain an individual in a healthy and safe environment, including cleaning surfaces and floors, making the individual's bed, cleaning dishes, taking out the garbage, dusting, and gathering and washing soiled clothing and linens.

(H) Arranging for necessary medical appointments including help scheduling appointments and arranging medical transportation services, assistance with mobility, and transfers or cognition in getting to and from appointments;

(I) Observation of an individual's status and reporting of significant changes to physicians, health care professionals, or other appropriate persons;

(J) First aid and handling emergencies, including responding to medical incidents related to conditions such as seizures, spasms, or uncontrollable movements where assistance is needed by another person, or responding to an individual's call for help during an emergent situation or for unscheduled needs requiring immediate response ; and

(K) Cognitive assistance or emotional support provided to an individual by another person due to developmental disability. This support includes helping the individual cope with change and assisting the individual with decision-making, reassurance, orientation, memory, or other cognitive symptoms.

(b) Personal care assistance means an individual requires help from another person with ADLs. Assistance may include cueing, monitoring, reassurance, redirection, set-up, hands-on, or standby assistance. Assistance may also require verbal reminding to complete one of the tasks described in subsection (b) of this section.

(A) "Cueing" means giving verbal or visual clues during an activity to help an individual complete the activity without hands-on assistance.

(B) "Hands-on" means a provider physically performs all or parts of an activity because an individual is unable to do so.

(C) "Monitoring" means a provider observes an individual to determine if intervention is needed.

(D) "Reassurance" means to offer an individual encouragement and support.

(E) "Redirection" means to divert an individual to another more appropriate activity.

(F) "Set-up" means getting personal effects, supplies, or equipment ready so that an individual may perform an activity.

(G) "Stand-by" means a provider is at the side of an individual ready to step in and take over the task should the individual be unable to complete the task independently.

(6) SKILLS TRAINING. Skills training are specifically tied to the FNAT and IHS Plan and are a means to increase independence, preserve functioning, and reduce dependency of an individual.

(7) TRANSPORTATION.

(a) Transportation services include but are not limited to:

(A) Transportation provided by common carriers, taxicab, or bus in accordance with standards established for these entities;

(B) Reimbursement on a per-mile basis for transporting an individual in a rural area into the nearest town once a week for shopping and recreational opportunities;

(C) Assistance with the purchase of a bus pass; and

(D) Reimbursement of operational expenses of agency or staff vehicles used for transporting individuals not to exceed established rates.

(b) Transportation services do not include medical transportation, purchase of individual or family vehicles, routine vehicle maintenance and repair, ambulance services, payment to the spouse of an individual receiving IHS services, and costs for transporting a person other than the individual.

(8) SPECIALIZED EQUIPMENT AND SUPPLIES. When specialized equipment and supplies are primarily and customarily used to serve a medical purpose, the purchase, rental, or repair of specialized equipment and supplies with IHS funds must be limited to the types of equipment and supplies that are not excluded under OAR 410-122-0080.

(a) Specialized equipment and supplies may include devices, aids, controls, supplies, or appliances primarily and customarily used to enable an individual to increase the individual's abilities to perform and support activities of daily living or to perceive, control, or communicate with the environment in which the individual lives.

(b) Specialized equipment and supplies may be purchased with IHS funds when an individual's intellectual or developmental disability otherwise prevents or limits the individual's independence in the areas described in section (5) of this rule

(c) Specialized equipment and supplies that may be purchased for the purpose described in subsection (b) of this section must be of direct benefit to the individual and include:

(A) Supplies needed to assist with incontinence care such as gloves, pads, wipes, or incontinence garments;

(B) Electronic devices to secure assistance in an emergency in the community and other reminders such as medication minders and alert systems for ADL or IADL supports, or mobile electronic devices;

(C) Assistive technology to provide additional security and replace the need for direct interventions to allow self direction of care and maximize independence such as motion/sound sensors, two-way communication systems, automatic faucets and soap dispensers, incontinent and fall sensors, or other electronic backup systems;

(i) Limit of $5000 per year without Department approval.

(ii) Any single device or assistance costing more than $500 in a plan year must be approved by the Department.

(D) Assistive devices. Examples include durable medical equipment, mechanical apparatus, electrical appliance or information technology device to assist and enhance an individual's independence in performing ADL/IADLs, not covered by other Medicaid programs.

(i) Limit of $5000 per year without Department approval.

(ii) Any single device or assistance costing more than $500 must be approved by the department.

(9) RESPITE.

(a) Respite may be provided in an individual's or respite provider's home, a foster home, a group home, a licensed day care center, or a community care facility that is not a private residence.

(b) Respite includes two types of care, neither of which may be characterized as eight-hours-a-day, five-days-a-week services or provided to allow an individual's provider to attend school or work.

(c) Temporary respite must be provided on less than a 24-hour basis.

(d) Twenty-four hour overnight services must be provided in segments of 24-hour units that may be sequential but may not exceed 14 consecutive days without permission from the Department.

(10) BEHAVIOR SUPPORT SERVICES.

(a) Behavior support services consist of:

(A) Assessment of an individual or the needs of the individual's family and the environment;

(B) Development of positive behavior support strategies including a Behavior Support Plan if needed;

(C) Implementation of a positive Behavior Support Plan with the provider or family; and

(D) Revision and monitoring of the plan as needed.

(b) Behavior support services may include:

(A) Training, modeling, and mentoring the family;

(B) Development of visual communication systems as behavior support strategies; and

(C) Communicating as authorized by the individual or their legal representative with school, medical, or other professionals about the strategies and outcomes of the Behavior Support Plan.

(c) Behavior support services does not include:

(A) Mental health therapy or counseling;

(B) Health or mental health plan coverage;

(C) Educational services, including, but not limited to, consultation and training for classroom staff;

(D) Adaptations to meet needs of the individual at school; or

(E) Assessment in the school setting.

(11) ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS.

(a) Environmental accessibility adaptations include but are not limited to:

(A) An environmental modification consultation to determine the appropriate type of adaptation;

(B) Installation of shatter-proof windows;

(C) Hardening of walls or doors;

(D) Specialized, hardened, waterproof, or padded flooring;

(E) An alarm system for doors or windows;

(F) Protective covering for smoke detectors, light fixtures, and appliances;

(G) Sound and visual monitoring systems;

(H) Fencing;

(I) Installation of ramps, grab-bars, and electric door openers;

(J) Adaptation of kitchen cabinets and sinks;

(K) Widening of doorways;

(L) Handrails;

(M) Modification of bathroom facilities;

(N) Individual room air conditioners for an individual whose temperature sensitivity issues create behaviors or medical conditions that put the individual or others at risk;

(O) Installation of non-skid surfaces;

(P) Overhead track systems to assist with lifting or transferring;

(Q) Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the individual;

(R) Modifications for the primary vehicle used by the individual that are necessary to meet the unique needs of the individual (lift or interior alterations such as seats, head, and leg rests; and belts, special safety harnesses, or other unique modifications to keep the individual safe in the vehicle); and

(S) Adaptations to control lights, heat, stove, etc.

(b) Environmental accessibility adaptations exclude:

(A) Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, and central air conditioning; and

(B) Adaptations that add to the total square footage of the home,

(c) Environmental modifications are limited to $5,000 per modification. A services coordinator may request approval for additional expenditures through the Department's prior to expenditure. Approval is based on the individual's need and goals and the Department's determination of appropriateness and cost-effectiveness.

(d) Environmental modifications must be tied to supporting activities of daily living, instrumental activities of daily living, and health-related tasks as identified in the IHS Plan.

(e) Modifications over $500 must be completed by a state licensed contractor. Any modification requiring a permit must be inspected and be certified as in compliance with local codes by a local inspector. Certification of compliance must be filed in the provider's file prior to payment.

(f) Environmental modifications must be made within the existing square footage of the home, except for external ramps, and may not add to the square footage of the home.

(g) Payment to the contractor is to be withheld until the work meets specifications.

(12) TRANSITION COSTS.

(a) Transition costs are limited to individuals transitioning from a nursing facility, intermediate are facility for the intellectually disabled, or acute care hospital to a home or community-based setting where the individual resides.

(b) Services are based on an individual's assessed need, determined during the person-centered service planning process and must support the desires and goals of the individual receiving services and supports. Final approval for expenditures must be through the Department prior to expenditure. Approval is based on the individual's need and the Department's determination of appropriateness and cost-effectiveness.

(c) Financial assistance is limited to:

(A) Moving and move-in costs including movers, cleaning and security deposits, payment for background/credit check (related to housing), initial deposits for heating, lighting, and phone;

(B) Payment of previous utility bills that may prevent the individual from receiving utility services and basic household furnishings (i.e. bed); and

(C) Other items necessary to re-establish a home.

(d) Transition costs are provided no more than twice annually

(e) Basic household furnishings and other items are limited to one time per year.

(13) ALTERNATIVES TO EMPLOYMENT - HABILITATION is assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that takes place in a non-residential setting, separate from the home in which an individual with an intellectual or developmental disability resides.

(14) PRE-VOCATIONAL SERVICES. The IHS Plan must reflect that prevocational services are directed to habilitative rather than explicit employment objectives.

(15) SUPPORTED EMPLOYMENT SERVICES. Supported employment services assist an individual to choose, get, and keep a paid job in an integrated community business setting.

(a) Supported employment services includes job development, training, and on-going supervision to obtain paid employment.

(b) Training may focus on the individual and the individual's coworkers without disabilities capable of providing natural support.

(c) Supported employment services must not replace services available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

(d) Supported employment services under this rule may not replace or duplicate services that the individual currently receives through the Department-contracted employment and alternative to employment services governed by OAR chapter 411, division 345.

(16) FAMILY TRAINING. Family training services are training and counseling services provided to the family of an individual to increase their capabilities to care for, support, and maintain the individual in the home.

(a) Family training services include but are not limited to:

(A) Instruction about treatment regimens and use of equipment specified in the IHS Plan;

(B) Information, education, and training about the individual's disability, medical, and behavioral conditions; and

(C) Organized conferences and workshops specifically related to the individual's disability, identified support needs, or specialized medical or behavioral support needs.

(b) Family training services may be provided in various settings by various means, including but not limited to psychologists licensed under ORS 675.030, professionals licensed to practice medicine under ORS 677.100 or nursing under ORS 678.040, social workers licensed under ORS 675.530, or counselors licensed under ORS 675.715;

(c) Examples of what family training services do not provide include, but are not limited to:

(A) Mental health counseling, treatment, or therapy;

(B) Training for paid caregivers;

(C) Legal fees;

(D) Training for families to carry out educational activities in lieu of school;

(E) Vocational training for family members; and

(F) Paying for training to carry out activities that constitute abuse of an adult.

(d) Prior authorization by the CDDP is required for attendance by family members at organized conferences and workshops funded with IHS funds.

(e) Family training may not be provided to paid caregivers.

(17) OCCUPATIONAL THERAPY. Occupational therapy services are the services of a professional licensed under ORS 675.240 that are defined and approved for purchase under the approved State Medicaid Plan, except that the limitation on amount, duration, and scope in the plan do not apply. These services are available to maintain an individual's skills or physical condition when prescribed by a physician and after the service limits of the State Medicaid Plan have been reached, either through private or public resources.

(a) Occupational therapy services include assessment, family training, consultation, and hands-on direct therapy provided by an appropriately licensed or certified occupational therapist when there is written proof that the Oregon Health Plan service limits have been reached.

(b) Occupational therapy services do not include:

(A) Goods and services available through other public programs (e.g. OHP, schools, or Federal assistance programs) for which an individual is eligible or through an individual's private insurance;

(B) Experimental therapy or treatments;

(C) Health and medical costs that the general public must pay;

(D) Legal fees; and

(E) Education services for an individual such as tuition to schools.

(18) PHYSICAL THERAPY. Physical therapy services are the services of a professional licensed under ORS 688.020 that are defined and approved for purchase under the approved State Medicaid Plan, except that the limitation on amount, duration, and scope in the plan do not apply. These services are available to maintain an individual's skills or physical condition when prescribed by a physician and after the service limits of the State Medicaid Plan have been reached, either through private or public resources.

(a) Physical therapy services include assessment, family training, consultation, and hands-on direct therapy provided by an appropriately licensed or certified physical therapist when there is written proof that the Oregon Health Plan service limits have been reached.

(b) Physical therapy services do not include:

(A) Goods and services available through either public programs (e.g. OHP, schools, or Federal assistance programs) for which an individual is eligible or through an individual's private insurance;

(B) Experimental therapy or treatments;

(C) Health and medical costs that the general public must pay;

(D) Legal fees; and

(E) Education services for an individual such as tuition to schools.

(19) SPEECH, HEARING, AND LANGUAGE SERVICES. Speech, hearing, and language services are the services of a professional licensed under ORS 681.250 that are defined and approved for purchase under the approved State Medicaid Plan, except that the limitation on amount, duration, and scope specified in the plan do not apply. These services are available to maintain an individual's skills or physical condition when prescribed by a physician and after the service limits of the State Medicaid Plan have been reached, either through private or public resources.

(a) Speech, hearing, and language services include assessment, family training, consultation, and hands-on direct therapy provided by an appropriately licensed or certified speech therapy professional when there is written proof that the Oregon Health Plan service limits have been reached.

(b) Speech, hearing, and language services do not include:

(A) Goods and services available through either public programs (e.g. OHP, schools, or Federal assistance programs) for which an individual is eligible, or through an individual's private insurance;

(B) Experimental therapy or treatments;

(C) Health and medical costs that the general public must pay;

(D) Legal fees; and

(E) Education services for an individual such as tuition to schools.

(20) Educational services for school age individuals, such as professional instruction, formal training, and tutoring in communication, socialization, and academic skills are not allowable expenses covered by (IHS) funds.

Stat. Auth.: ORS 410.070 & 409.050

Stats. Implemented: ORS 430.610 - 430.670 & 427.005 - 427.007

Hist.: SPD 21-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 25-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

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Rule Caption: Employment and Alternatives to Employment Services for Adults with Intellectual or Developmental Disabilities

Adm. Order No.: SPD 26-2013(Temp)

Filed with Sec. of State: 7-1-2013

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Notice Publication Date:

Rules Amended: 411-345-0020, 411-345-0140

Subject: The Department of Human Services (Department) is immediately amending the employment and alternatives to employment services rules for adults with intellectual or developmental disabilities in OAR chapter 411, division 345 to:

Specify the eligibility requirements for home and community-based waivered services to reflect changes made as a result of the Department's Community First Choice State Plan; and

Clarify the notice requirements and hearing rights for involuntary transfers and exits to comply with the Code of Federal Regulations and implement corrective actions required as a result of the Centers for Medicare and Medicaid Services' (CMS) review of the Department's Home and Community-Based Services Waiver.

Rules Coordinator: Christina Hartman—(503) 945-6398

411-345-0020

Definitions

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 345:

(1) "Abuse" means abuse of an adult as defined in OAR 407-045-0260.

(2) "Abuse Investigation and Protective Services" means reporting and investigation activities as required by OAR 407-045-0300 and any subsequent services or supports necessary to prevent further abuse as required in OAR 407-045-0310.

(3) "Administration of Medication" means the act of placing a medication in or on an individual's body by a staff member who is responsible for the individual's care.

(4) "Adult" means an individual 18 years or older with an intellectual or developmental disability.

(5) "Advocate" means a person other than paid staff who has been selected by an individual or by the individual's legal representative to help the individual understand and make choices in matters relating to identification of needs and choices of services, especially when rights are at risk or have been violated.

(6) "Aid to Physical Functioning" means any special equipment prescribed for an individual by a physician, therapist, or dietician that maintains or enhances the individual's physical functioning.

(7) "Alternatives to Employment Services" mean any services conducted away from an individual's residence that addresses the academic, recreational, social, or therapeutic needs of the individual for whom it serves.

(8) "Annual Individual Support Plan (ISP) Meeting" means an annual meeting, facilitated by an individual's services coordinator and attended by an individual's ISP team. The purpose of the meeting is to determine an individual's needs, coordinate services and training, and develop the individual's ISP.

(9) "Case Management" means an organized service to assist individuals to select, obtain, and utilize resources and services.

(10) "CDDP" means "Community Developmental Disability Program" as defined in this rule.

(11) "Certificate" means the document issued by the Department to a service provider that certifies the service provider is eligible under the rules in OAR chapter 411, division 323 to receive state funds for the provision of endorsed employment and alternatives to employment services.

(12) "Choice" means an individual's expression of preference, opportunity for, and active role in decision-making related to services received and from whom, including but not limited to case management, service providers, and service settings. Personal outcomes, goals, and activities are supported in the context of balancing an individual's rights, risks, and personal choices. Individuals are supported in opportunities to make changes when so expressed. Choice may be communicated verbally, through sign language, or by other communication methods.

(13) "Community Based Service" means any service or program providing opportunities for the majority of an individual's time to be spent in community participation or integration.

(14) "Community Developmental Disability Program (CDDP)" means the entity that is responsible for the planning and delivery of services for individuals with intellectual or developmental disabilities according to OAR chapter 411, division 320. A CDDP operates in a specific geographic service area of the state under a contract with the Department, local mental health authority, or other entity as contracted by the Department.

(15) "Community First Choice State Plan" means Oregon's state plan amendment authorized under section 1915(k) of the Social Security Act.

(16) "Complaint Investigation" means the investigation of any complaint that has been made to a proper authority that is not covered by an abuse investigation.

(17) "Controlled Substance" means any drug classified as Schedules 1 to 5 under the Federal Controlled Substance Act.

(18) "Department" means the Department of Human Services (DHS). The term "Department" is synonymous with "Seniors and People with Disabilities Division (SPD)".

(19) "Developmental Disability" means a neurological condition that originates in the developmental years, that is likely to continue, and significantly impacts adaptive behavior as diagnosed and measured by a qualified professional as described in OAR 411-320-0080.

(20) "Director" means the Director of the Department's Office of Developmental Disability Services, or the Director's designee.

(21) "Discovery" is a focused time-limited service engaging a participant in identifying their strengths, needs, and interests to prepare for integrated employment.

(22) "Employment Services" means any service that has as its primary goal the employment of individuals, including job assessment, job development, training, and ongoing supports.

(23) "Endorsement" means the authorization to provide employment and alternatives to employment services issued by the Department to a certified service provider that has met the qualification criteria outlined in these rules and the rules in OAR chapter 411, division 323.

(24) "Entry" means admission to a Department-funded developmental disability service.

(25) "Executive Director" means the person designated by a board of directors or corporate owner that is responsible for the administration of employment and alternatives to employment services.

(26) "Exit" means termination or discontinuance of --

(a) Services from a service provider; or

(b) Department-funded developmental disability services.

(27) "Facility Based Service" means any service or program operated by a service provider that occurs in a location supporting more than eight individuals as a group.

(28) "Founded Reports" means the Department's or Law Enforcement Authority's (LEA) determination, based on the evidence, that there is reasonable cause to believe that conduct in violation of the child abuse statutes or rules has occurred and such conduct is attributable to the person alleged to have engaged in the conduct.

(29) "Functional Needs Assessment (FNAT)" means an assessment that documents the level of need, accommodates a child's participation in service planning, and includes:

(a) Completing a comprehensive and holistic assessment;

(b) Surveying physical, mental, and social functioning; and

(c) Identifying risk factors, choices and preferences, and service needs.

(30) "Home and Community-Based Waivered Services" mean the services approved by the Centers for Medicare and Medicaid Services in accordance with Section 1915(c) and 1115 of the Social Security Act.

(31) "Important for an Individual" means the areas of life that relate to being healthy, safe, and a valued member of the community.

(32) "Important to an Individual" means an individual's perspective on the people, places, and things they like, personal values, spirituality, and a sense of self. This is learned by listening to what is being said by words or actions. When there is a conflict between words and actions, actions are considered first.

(33) "Incident Report" means the written report of any injury, accident, acts of physical aggression, or unusual incident involving an individual.

(34) "Independence" means the extent to which individuals exert control and choice over their own lives.

(35) "Individual" means an adult with an intellectual or developmental disability applying for or determined eligible for developmental disability services.

(36) "Individual Support Plan (ISP)" means the written details of the supports, activities, and resources required for an individual to achieve personal outcomes. Individual support needs are identified through a Functional Needs Assessment. The manner in which services are delivered, service providers, and the frequency of services are reflected in an ISP. The ISP is developed at minimum annually to reflect decisions and agreements made during a person-centered process of planning and information gathering. The ISP includes an individual's Plan of Care for Medicaid purposes and reflects whether services are purchased through a waiver, state plan, or provided through an individual's natural supports.

(37) "Individual Support Plan (ISP) Action Plan" means the written documentation of the ISP team's commitment in supporting an individual to resolve or improve particular aspects of the individual's life. An ISP Action Plan identifies the necessary measurable steps to be taken, who is accountable for assuring implementation, and timelines for completion.

(38) "Individual Support Plan (ISP) Team" means a team composed of an individual receiving services and the individual's legal representative, services coordinator or personal agent, and others chosen by the individual. Others chosen by the individual may include service providers, family members, or other persons requested by the individual.

(39) "Integration" as defined in ORS 427.005 means:

(a) The use by individuals with intellectual or developmental disabilities of the same community resources used by and available to other persons;

(b) Participation by individuals with intellectual or developmental disabilities in the same community activities in which persons without an intellectual or developmental disability participate, together with regular contact with persons without an intellectual or developmental disability; and

(c) Individuals with intellectual or developmental disabilities reside in homes or home-like settings that are in proximity to community resources and foster contact with persons in the community.

(40) "Intellectual Disability" has the meaning set forth in OAR 411-320-0020 and described in 411-320-0080.

(41) "Involuntary Transfer" means a service provider has made the decision to transfer an individual and the individual or the individual's legal representative has not given prior approval.

(42) "ISP" means "Individual Support Plan" as defined in this rule.

(43) "Job Development" means assistance and support for individuals to pursue employment and obtain job placement.

(44) "Legal Representative" means for an adult, an attorney at law who has been retained by or for an individual or a person or agency authorized by a court to make decisions about services for the individual.

(45) "Level of Care" means an assessment completed by a services coordinator has determined an individual meets institutional level of care. An individual meets institutional level of care for an intermediate care facility for individuals with intellectual or developmental disabilities if:

(a) The individual has a condition of an intellectual disability or a developmental disability as defined in OAR 411-320-0020 and meets the eligibility criteria for developmental disability services as described in OAR 411-320-0080; and

(b) The individual has a significant impairment in one or more areas of adaptive functioning. Areas of adaptive functioning include self direction, self care, home living, community use, social, communication, mobility, or health and safety.

(46) "Mandatory Reporter" means any public or private official as defined in OAR 407-045-0260 who, is a staff or volunteer working with an adult who, while acting in an official capacity, comes in contact with and has reasonable cause to believe an adult with an intellectual or developmental disability has suffered abuse, or comes in contact with any person whom the official has reasonable cause to believe abused an adult with an intellectual or developmental disability. Nothing contained in ORS 40.225 to 40.295 affects the duty to report imposed by this section of this rule, except that a psychiatrist, psychologist, clergy, or attorney is not required to report if the communication is privileged under 40.225 to 40.295.

(47) "Medicaid Agency Identification Number" means the numeric identifier assigned by the Department to a service provider following the service provider's enrollment as described in OAR chapter 411, division 370.

(48) "Medicaid Performing Provider Number" means the numeric identifier assigned to an entity or person by the Department, following enrollment to deliver Medicaid funded services as described in OAR chapter 411, division 370. The Medicaid Performing Provider Number is used by the rendering service provider for identification and billing purposes associated with service authorizations and payments.

(49) "Medication" means any drug, chemical, compound, suspension, or preparation in suitable form for use as a curative or remedial substance taken either internally or externally by any person.

(50) "Natural Supports" or "Natural Support System" means the resources available to an individual from the individual's relatives, friends, significant others, neighbors, roommates, and the community. Services provided by natural supports are resources that are not paid for by the Department.

(51) "Oregon Intervention System (OIS)" means the system of providing training to people who work with designated individuals to provide elements of positive behavior support and non-aversive behavior intervention. OIS uses principles of pro-active support and describes approved protective physical intervention techniques that are used to maintain an individual's health and safety.

(52) "OSIP-M" means Oregon Supplemental Income Program-Medical as defined in OAR 461-101-0010. OSIP-M is Oregon Medicaid insurance coverage for an individual who meets eligibility criteria as described in OAR chapter 461.

(53) "Path to Employment" means a concept that identifies an individual's preferences in moving toward employment using principles of self-determination and a set of questions and strategies that assist the Individual Support Plan team when planning.

(54) "Person-Centered Planning" means:

(a) A process, either formal or informal, for gathering and organizing information that helps an individual:

(A) Determine and describe choices about employment or personal goals, activities, and lifestyle preferences; and

(B) Identify, use, and strengthen naturally occurring opportunities for support in the community.

(b) The methods for gathering information vary, but all are consistent with individual needs and preferences.

(55) "Person-Centered Process" means a practice of identifying what is important to and for an individual, and the supports necessary to address issues of health, safety, behavior, and financial support.

(56) "Productivity" as defined in ORS 427.005 means:

(a) Engagement in income producing work by an individual that is measured through improvements in income level, employment status, or job advancement; or

(b) Engagement by an individual in work contributing to a household or community.

(57) "Protection" means the necessary actions taken as soon as possible to prevent subsequent abuse or exploitation of an individual, to prevent self-destructive acts, or to safeguard an individual's person, property, and funds.

(58) "Protective Physical Intervention (PPI)" means any manual physical holding of, or contact with, an individual that restricts the individual's freedom of movement. The term "protective physical intervention" is synonymous with "physical restraint".

(59) "Psychotropic Medication" means medication the prescribed intent of which is to affect or alter thought processes, mood, or behavior including but not limited to anti-psychotic, antidepressant, anxiolytic (anti-anxiety), and behavior medications. The classification of a medication depends upon its stated, intended effect when prescribed.

(60) "Self-Administration of Medication" means an individual manages and takes his or her own medication, identifies his or her own medication and the times and methods of administration, places the medication internally in or externally on his or her own body without staff assistance upon the written order of a physician, and safely maintains the medication without supervision.

(61) "Self-Determination" means a philosophy and process by an individual is empowered to gain control over the selection of services that meet the individual's needs. The basic principles of self-determination are:

(a) Freedom. The ability for an individual, together with freely chosen family, friends, and professionals, to plan for employment beyond the parameters of a predefined program;

(b) Authority. The ability for an individual, together with the Individual Support Plan team, to declare a chosen employment path and to plan supports accordingly.

(c) Autonomy. Planning for and accessing resources that support an individual to seek employment; and

(d) Responsibility. The acceptance of a valued role in an individual's community through employment, organizational affiliations, personal development, and general caring for others in the community, as well as accountability for spending public dollars in ways that are life-enhancing for individuals.

(62) "Service Provider" or "Service" means a public or private community agency or organization that provides recognized developmental disability services and is certified and endorsed by the Department to provide these services under these rules and the rules in OAR chapter 411, division 323. The use of the terms "agency", "provider", or "program" are synonymous with "service provider".

(63) "Services Coordinator" means an employee of a community developmental disability program or other agency that contracts with the county or Department, who is selected to plan, procure, coordinate, and monitor Individual Support Plan services and to act as a proponent for individuals.

(64) "Staff" means paid employees responsible for providing services to individuals whose wages are paid in part or in full with funds contracted with the community developmental disability program or contracted directly through the Department.

(65) "Substantiated" means an abuse investigation has been completed by the Department or the Department's designee and the preponderance of the evidence establishes the abuse occurred.

(66) "Support" means the assistance that an individual requires, solely because of the affects of an intellectual or developmental disability, to maintain or increase independence, achieve community presence and participation, and improve productivity. Support is subject to change with time and circumstances.

(67) "Supported Employment" means the provision of situational assessment, job development, job training, and ongoing support necessary to place, maintain, or change the employment of an individual in an integrated work setting. The individual is compensated in accordance with the Fair Labor Standards Act.

(68) "These Rules" mean the rules in OAR chapter 411, division 345.

(69) "Transfer" means movement of an individual from one site to another site administered or operated by the same service provider.

(70) "Transition Plan" means the written plan of services and supports for the period of time between an individual's entry into a particular service and the development of the individual's Individual Support Plan (ISP). The Transition Plan is approved by the individual's services coordinator and includes a summary of the services necessary to facilitate adjustment to the services offered, the supports necessary to ensure health and safety, and the assessments and consultations necessary for ISP development.

(71) "Unit of Service" means the equivalent of an individual receiving services 25 hours per week, 52 weeks per year minus the following:

(a) Personal, vacation, or sick leave allowed by a service provider or employer;

(b) Holidays as recognized by the state of Oregon; and

(c) Up to four days for all-staff in-service training.

(72) "Unusual Incident" means any incident involving an individual that includes serious illness or an accident, death, injury or illness requiring inpatient or emergency hospitalization, suicide attempts, a fire requiring the services of a fire department, or any incident requiring an abuse investigation.

(73) "Variance" means the temporary exception from a regulation or provision of these rules that may be granted by the Department upon written application by a service provider.

(74) "Volunteer" means any person assisting a service provider without pay to support the services provided to an individual.

Stat. Auth.: ORS 409.050 & 410.070

Stats. Implemented: ORS 430.610, 430.630 & 430.670

Hist.: MHD 26-1982(Temp), f. & ef. 12-3-82; MHD 9-1983, f. & ef. 6-7-83; MHD 7-1990(Temp), f. & cert. ef. 6-12-90; MHD 13-1990, f. & cert. ef. 12-7-90; MHD 1-1997, f. & cert. ef. 1-31-97; Renumbered from 309-047-0005, SPD 23-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 12-2010, f. 6-30-10, cert. ef. 7-1-10; SPD 14-2011, f. & cert. ef. 7-1-11; SPD 19-2011(Temp), f. & cert. ef. 7-1-11 thru 12-28-11; SPD 1-2012, f. & cert. ef. 1-6-12; SPD 26-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-345-0140

Entry, Exit and Transfer

(1) NON-DISCRIMINATION. An individual considered for Department-funded services may not be discriminated against because of race, color, creed, age, disability, national origin, gender, religion, duration of Oregon residence, method of payment, or other forms of discrimination under applicable state or federal law.

(2) QUALIFICATIONS FOR DEPARTMENT-FUNDED SERVICES PRIOR TO JULY 1, 2013. An individual considered for Department-funded services must:

(a) Be referred by the CDDP;

(b) Be determined to have a developmental disability by the Department or the Department's designee;

(c) Be 18 years of age or older and not eligible to receive public education services under Public Law 94-142; and

(d) Be an individual also receiving residential services that are paid or regulated by the Department including but not limited to:

(A) Comprehensive 24-hour residential services regulated by OAR chapter 411, division 325;

(B) An adult foster home regulated by OAR chapter 411, division 360;

(C) A supported living program regulated by OAR chapter 411, division 328; or

(D) An individual's own home or family home when the individual receives comprehensive in-home support services provided according to OAR chapter 411, division 330.

(3) QUALIFICATIONS FOR DEPARTMENT-FUNDED SERVICES ON OR AFTER JULY 1, 2013. An individual who enters 24-hour residential services on or after July 1, 2013, is subject to eligibility as described in this section.

(a) To be eligible for home and community-based waivered services or Community First Choice State Plan services, an individual must:

(A) Be an Oregon resident;

(B) Be eligible for OSIP-M;

(C) Be determined eligible for developmental disability services by the CDDP of the individual's county of residence as described in OAR 411-320-0080; and

(d) After completion of an assessment, meet the level of care as defined in OAR 411-345-0020.

(b) To be eligible for employment and alternatives to employment services, an individual must:

(A) Be an Oregon resident;

(B) Be determined eligible for developmental disability services by the CDDP of the individual's county of residence as described in OAR 411-320-0080;

(C) Be 18 years of age or older and not eligible to receive public education services under Public Law 94-142;

(D) Be an individual also receiving residential services that are paid or regulated by the Department including but not limited to:

(i) Comprehensive residential services regulated by OAR chapter 411, division 325;

(ii) An adult foster home regulated by OAR chapter 411, division 360;

(iii) A supported living program regulated by OAR chapter 411, division 328; or

(iv) An individual's own or family home when the individual receives comprehensive in-home support services that are provided according to OAR chapter 411, division 330; and

(E) Be eligible for home and community-based waivered services or Community First Choice State Plan services as described in subsection (a) of this section; OR

(F) Be determined to meet crisis eligibility as defined in OAR 411-320-0160.

(4) ENTRY. An entry ISP team meeting must be conducted prior to the initiation of services to an individual.

(a) A service provider must acquire the following information prior to or upon an individual's entry ISP team meeting:

(A) A copy of the individual's eligibility determination document;

(B) A statement indicating the individual's safety skills including the individual's ability to evacuate from a building when warned by a signal device;

(C) A brief written history of the individual's behavioral challenges, if any, including supervision and support needs;

(D) Documentation of the individual's current physical condition, including any physical limitations that may affect employment;

(E) Documentation of any guardianship or conservatorship, or any other legal restriction on the rights of the individual, if applicable; and

(F) A copy of the individual's most recent ISP, if applicable.

(b) The findings of the entry meeting must be recorded in the individual's file and include at a minimum:

(A) The name of the individual proposed for services;

(B) The date of the meeting;

(C) The date determined to be the individual's date of entry;

(D) Documentation of the participants at the meeting;

(E) Documentation as required by OAR 411-345-0190 and 411-345-0200;

(F) Documentation of the pre-entry information required by subsection (a) of this section;

(G) Documentation of the proposed transition plan for services to be provided;

(H) Documentation of any deviation from the unit of service;

(I) Documentation of the type of employment or alternatives to employment service the individual will receive; and

(J) Documentation of the decision to serve or not serve the individual requesting service, including the reason for the determination to not serve the individual.

(5) VOLUNTARY TRANSFERS AND EXITS.

(a) If an individual or the individual's legal representative gives notice of the individual's intent to exit, or the individual abruptly exits services, the service provider must promptly notify the individual's services coordinator.

(b) A service provider must notify an individual's ISP team prior to the individual's voluntary transfer or exit from services.

(c) Notification and authorization of the individual's voluntary transfer or exit must be documented in the individual's record.

(6) INVOLUNTARY TRANSFERS AND EXITS.

(a) A service provider may only transfer or exit an individual involuntarily for one or more of the following reasons:

(A) To protect the health, safety, and welfare of the individual or others;

(B) The individual's service needs exceed the ability of the service provider;

(C) The individual fails to pay for services; or

(D) The service provider's Developmental Disability Certification or Endorsement as described in OAR chapter 411, division 323 is suspended, revoked, not renewed, or voluntarily surrendered.

(b) NOTICE OF INVOLUNTARY TRANSFER OR EXIT. A service provider may not transfer or exit an individual involuntarily without 30 days advance written notice to the individual and the individual's legal representative and services coordinator except in the case of a medical emergency or when an individual is engaging in behavior that poses an imminent danger to self or others as described in subsection (c) of this section.

(A) The written notice must be provided on a form approved by the Department (form SDS 0719) and include:

(i) The reason for the transfer or exit; and

(ii) The individual's right to a hearing as described in subsection (d) of this section.

(B) A notice is not required when an individual or the individual's legal representative requests a transfer or exit.

(c) A service provider may give less than 30 days advanced written notice only in a medical emergency or when an individual is engaging in behavior that poses an imminent danger to self or others. The notice must be provided to the individual and the individual's legal representative and services coordinator immediately upon determination of the need for a transfer or exit.

(d) HEARING RIGHTS. An individual must be given the opportunity for a contested case hearing under ORS 183 to dispute an involuntary transfer or exit. If an individual or the individual's representative requests a hearing, the individual must receive the same services until the hearing is resolved. When an individual has been given less than 30 days advanced written notice of an exit or transfer as described in subsection (c) of this section and the individual or the individual's representative has requested a hearing, the service provider must reserve service availability for the individual until receipt of the Final Order.

(7) EXIT.

(a) An individual's ISP team must meet before any decision to exit is made. Findings of such a meeting must be recorded in the individual's file and include at a minimum:

(A) The name of the individual considered for exit;

(B) The date of the meeting;

(C) Documentation of the participants included in the meeting;

(D) Documentation of the circumstances leading to the proposed exit;

(E) Documentation of the discussion of the strategies to prevent the individual's exit from service (unless the individual or the individual's legal representative is requesting the exit);

(F) Documentation of the decision regarding the individual's exit including verification of the voluntary decision to transfer or exit or a copy of the Notice of Involuntary Transfer or Exit; and

(G) Documentation of the proposed plan for services to the individual after the exit.

(b) Requirements for an exit meeting may be waived if an individual is immediately removed from the service under the following conditions:

(A) The individual or the individual's legal representative requests an immediate removal from the service; or

(B) The individual is removed by legal authority acting pursuant to civil or criminal proceedings.

(8) TRANSFER. A meeting of the ISP Team to discuss any proposed transfer of an individual must precede the decision to transfer. Findings of such a meeting must be recorded in the individual's file and include at a minimum:

(a) The name of the individual considered for transfer;

(b) The date of the meeting or telephone call;

(c) Documentation of the participants included in the meeting or telephone call;

(d) Documentation of the circumstances leading to the proposed transfer;

(e) Documentation of the alternatives considered instead of transfer;

(f) Documentation of the reasons any preferences of the individual or the individual's legal representative or family members cannot be honored;

(g) Documentation of a majority agreement of the participants regarding the decision; and

(h) The written plan for services to the individual after transfer.

(9) APPEAL. Any member of the ISP team may file an appeal in cases where an individual or the individual's legal representative or advocate object to, or the ISP team cannot reach majority agreement regarding an admission refusal. In the case of a request to exit or transfer, the individual must continue to receive the same services received prior to the appeal until the appeal is resolved.

(a) All appeals must be made in writing to the CDDP Director or the CDDP Directors designee for decision using the county's appeal process. The CDDP Director must make a decision within 30 working days of receipt of the appeal and notify the appellant of the decision in writing.

(b) The decision of the CDDP Director may be appealed by the individual, the individual's legal representative, advocate, or the service provider by notifying the Department in writing within 10 working days of receipt of the CDDP's decision.

(A) The Director shall appoint a committee composed of a Department representative, a service representative, and a services coordinator.

(B) In case of a conflict of interest, as determined by the Director, alternative representatives may be temporarily appointed by the Director to the committee.

(C) The committee must review the appealed decision and make a written recommendation to the Director within 45 working days of receipt of the notice of appeal.

(D) The Director makes a decision on the appeal within 10 working days after receipt of the recommendation from the committee.

(E) If the decision is for admission or continued placement and the service refuses admission or continued placement, the funding for that unit of service may be withdrawn by the contractor.

Stat. Auth.: ORS 409.050 & 410.070
Stats. Implemented: ORS 430.610, 430.630 & 430.670
Hist.: MHD 7-1990(Temp), f. & cert. ef. 6-12-90; MHD 13-1990, f. & cert. ef. 12-7-90; MHD 1-1997, f. & cert. ef. 1-31-97; MHD 2-2003(Temp), f. & cert. ef. 7-1-03 thru 12-27-03; Renumbered from 309-047-0065, SPD 23-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 14-2011, f. & cert. ef. 7-1-11; SPD 26-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

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Rule Caption: Foster Homes for Children with Intellectual or Developmental Disabilities
Adm. Order No.: SPD 27-2013(Temp)
Filed with Sec. of State: 7-1-2013
Certified to be Effective: 7-1-13 thru 12-28-13
Notice Publication Date:
Rules Amended: 411-346-0110, 411-346-0180
Subject: The Department of Human Services (Department) is immediately amending the foster home rules for children with intellectual or developmental disabilities in OAR chapter 411, division 346 to clarify the notice requirements and hearing rights for involuntary transfers or exits. The temporary rules comply with the Code of Federal Regulations and implement corrective actions required as a result of the Centers for Medicare and Medicaid Services' (CMS) review of the Department's Home and Community-Based Services Waiver.
Rules Coordinator: Christina Hartman—(503) 945-6398

411-346-0110
Definitions

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 346:

(1) "Abuse" means:

(a) Abuse of a child under the age of 18 as defined in ORS 419B.005; and

(b) Abuse of an adult as defined in OAR 407-045-0260 when an individual between the ages of 18 and 21 resides in a certified child foster home.

(2) "Alternate Caregiver" means any person 18 and older responsible for the care or supervision of a child in foster care.

(3) "Alternative Educational Plan (AEP)" means any school plan that does not occur within the physical school setting.

(4) "Appeal" means the process for a contested hearing under ORS chapter 183 that the foster provider may use to petition the suspension, denial, non-renewal, or revocation of their certificate or application.

(5) "Applicant" means a person who wants to become a child foster provider, lives at the residence where a child in foster care shall live, and is applying for a child foster home certificate or is renewing a child foster home certificate.

(6) "Assistant Director" means Director as defined in this rule.

(7) "Aversive Stimuli" means the use of any natural or chemical product to alter a child's behavior such as the use of hot sauce or soap in the mouth and spraying ammonia or lemon water in the face of a child. Psychotropic medications are not considered aversive stimuli.

(8) "Behavior Supports" means a positive training plan used by the foster provider and alternate caregivers to help a child in foster care develop the self control and self direction necessary to assume responsibilities, make daily living decisions, and learn to conduct themselves in a manner that is socially acceptable.

(9) "Case Plan" means the goal-oriented, time-limited, individualized plan of action for a child and the child's family developed by the child's family and the Department's Children, Adults, and Families Division for promotion of the child's safety, permanency, and well being.

(10) "Case Worker" means an employee of the Department's Children, Adults, and Families Division.

(11) "Certificate" means a document issued by the Department that notes approval to operate a child foster home for a period not to exceed two years.

(12) "Certifier" or "Certifying Agency" means the Department, Community Developmental Disability Program, or an agency approved by the Department who is authorized to gather required documentation to issue or maintain a child foster home certificate.

(13) "Child" means:

(a) An individual under the age of 18 who has a provisional eligibility determination of an intellectual or developmental disability by the Community Developmental Disability Program; or

(b) A young adult age 18 through 21 with an intellectual or developmental disability who is remaining in the same foster home for the purpose of completing their Individualized Education Plan, based on their Individual Support Plan team recommendation and an approved certification variance.

(14) "Child Foster Home (CFH)" means a home certified by the Department that is maintained and lived in by the person named on the foster home certificate.

(15) "Child Foster Home Contract" means an agreement between a provider and the Department that describes the responsibility of the foster care provider and the Department.

(16) "Child Placing Agency" means the Department, Community Developmental Disability Program, or the Oregon Youth Authority.

(17) "Commercial Basis" means providing and receiving compensation for the temporary care of individuals not identified as members of the household.

(18) "Community Developmental Disability Program (CDDP)" means the entity that is responsible for the planning and delivery of services for individuals with intellectual or developmental disabilities in a specific geographic service area of the state operated by or under a contract with the Department or a local mental health authority.

(19) "Denial" means the refusal of the certifying agency to issue a certificate of approval to operate a child foster home because the certifying agency has determined that the home or the applicant is not in compliance with one or more of these rules.

(20) "Department" means the Department of Human Services (DHS). The term "Department" is synonymous with "Seniors and People with Disabilities Division (SPD)(Division)".

(21) "Developmental Disability (DD)" means a neurological condition that originates in the developmental years, that is likely to continue, and significantly impacts adaptive behavior as diagnosed and measured by a qualified professional as described in OAR 411-320-0080. (22) "DHS-CW" means the child welfare program area within the Department's Children, Adults, and Families Division.

(23) "Direct Nursing Services" means the provision of individual-specific advice, plans, or interventions by a nurse at a home based on the nursing process as outlined by the Oregon State Board of Nursing. Direct nursing service differs from administrative nursing services. Administrative nursing services include non-individual-specific services, such as quality assurance reviews, authoring health related agency policies and procedures, or providing general training for the foster provider or alternate caregivers.

(24) "Discipline" for the purpose of these rules, discipline is synonymous with behavior supports.

(25) "Division" means Department as defined in this rule.

(26) "Domestic Animals" mean the animals domesticated so as to live and breed in a tame condition. Examples of domestic animals include but are not limited to dogs, cats, and domesticated farm stock.

(27) "Educational Surrogate" means the person who acts in place of a parent in safeguarding a child's rights in the special education decision-making process:

(a) When the parent cannot be identified or located after reasonable efforts;

(b) When there is reasonable cause to believe that the child has a disability and is a ward of the state; or

(c) At the request of the parent or adult student.

(28) "Emergency Certificate" means a foster home certificate issued for 30 days.

(29) "Exit" means termination or discontinuance of

(a) Services from a foster provider; or

(b) Department-funded developmental disability services.

(30) "Foster Care" means a child is placed away from their parent or guardian in a certified child foster home.

(31) "Foster Provider" means the certified care provider who resides at the address listed on the foster home certificate. The term "foster provider" is synonymous with child foster parent or relative caregiver and is considered a private agency for purposes of mandatory reporting of abuse.

(32) "Founded Reports" means the Department's Children, Adults, and Families Division or Law Enforcement Authority (LEA) determination, based on the evidence, that there is reasonable cause to believe that conduct in violation of the child abuse statutes or rules has occurred and such conduct is attributable to the person alleged to have engaged in the conduct.

(33) "Guardian" means a parent for individuals less than 18 years of age or a person or agency appointed and authorized by an Oregon court to make decisions about services for an individual in foster care.

(34) "Health Care Provider" means the person or health care facility licensed, certified, or otherwise authorized or permitted by Oregon law to administer health care in the ordinary course of business or practice of a profession.

(35) "Home Inspection" means an on-site, physical review of the applicant's home to assure the applicant meets all health and safety requirements within these rules.

(36) "Home Study" means the assessment process used for the purpose of determining an applicant's abilities to care for a child in need of foster care placement.

(37) "Incident Report" means the written report of any unusual incident involving the child in foster care.

(38) "Individualized Education Plan (IEP)" means the written plan of instructional goals and objectives developed in conference with a teacher, a student and the student's parent or guardian, and a representative of the school district.

(39) "Individual Support Plan (ISP)" means the written details of the supports, activities, and resources required for a child to achieve personal outcomes. Individual support needs are identified through a functional needs assessment. The manner in which services are delivered, service providers, and the frequency of services are reflected in an ISP. The ISP is developed at minimum annually to reflect decisions and agreements made during a person-centered process of planning and information gathering. The ISP includes a child's plan of care for Medicaid purposes and reflects whether services are provided through a waiver, state plan, or through a child's natural supports.

(40) "Individual Support Plan (ISP) Team" means a team composed of:

(a) The child in foster care when appropriate;

(b) The foster provider;

(c) The child's guardian;

(d) The Community Developmental Disability Program services coordinator; and

(e) Others chosen by the child or the child's guardian that may include providers, family members, or other persons requested by the child or the child's guardian.

(41) 'Intellectual Disability" has the meaning set forth in OAR 411-320-0020 and described in 411-320-0080.

(42) "Involuntary Transfer" means a foster provider has made the decision to transfer a child and the child or the child's guardian has not given prior approval.

(43) "Licensed Medical Professional" means a person who meets the following:

(a) Holds at least one of the following valid licensures or certifications:

(A) Physician licensed to practice in Oregon;

(B) Nurse practitioner certified by the Oregon State Board of Nursing under ORS 678.375; or

(C) Physician's assistant licensed to practice in Oregon; and

(b) Whose training, experience, and competence demonstrate expertise in children's mental health, the ability to conduct a mental health assessment, and provide psychotropic medication management for a child in foster care.

(44) "Mandatory Reporter" means any public or private official who:

(a) Is a foster provider, staff, or volunteer working with a child who, comes in contact with and has reasonable cause to believe a child with or without an intellectual or developmental disability has suffered abuse, or comes in contact with any person whom the official has reasonable cause to believe abused a child with or without an intellectual or developmental disability, regardless of whether or not the knowledge of the abuse was gained in the reporter's official capacity. Nothing contained in ORS 40.225 to 40.295 affects the duty to report imposed by this section, except that a psychiatrist, psychologist, clergy, attorney, or guardian ad litem appointed under 419B.231 is not required to report if the communication is privileged under 40.225 to 40.295.

(b) Is a foster provider, staff, or volunteer working with individuals 18 years and older who, while acting in an official capacity, comes in contact with and has reasonable cause to believe an adult with an intellectual or developmental disability has suffered abuse, or comes in contact with any person whom the official has reasonable cause to believe abused an adult with an intellectual or developmental disability. Nothing contained in ORS 40.225 to 40.295 affects the duty to report imposed by this section, except that a psychiatrist, psychologist, clergy, attorney, or guardian ad litem appointed under 419B.231 is not required to report if the communication is privileged under 40.225 to 40.295.

(45) "Mechanical Restraint" means any mechanical device, material, object, or equipment that is attached or adjacent to an individual's body that the individual cannot easily remove or easily negotiate around that restricts freedom of movement or access to the individual's body.

(46) "Member of the Household" means any adults and children living in the home, including any employees or volunteers assisting in the care provided to a child placed in the home. A child in foster care is not considered a member of the household.

(47) "Mental Health Assessment" means the determination of a child's need for mental health services by interviewing the child and obtaining all pertinent biopsychosocial information, as identified by the child, the child's family, and collateral sources that:

(a) Addresses the current complaint or condition presented by the child;

(b) Determines a diagnosis; and

(c) Provides treatment direction and individualized services and supports.

(48) "Misuse of Funds" includes but is not limited to providers or their staff:

(a) Borrowing from or loaning money to a child in foster care;

(b) Witnessing a will in which the provider or a staff is a beneficiary;

(c) Adding the provider's name to a child's bank account or other titles for personal property without approval of the child, when of age to give legal consent, or the child's guardian and authorization of the child's Individual Support Plan team;

(d) Inappropriately expending or theft of a child's personal funds;

(e) Using a child's personal funds for the provider's or staff's own benefit; or

(f) Commingling a child's funds with provider or another child's funds.

(49) "Monitoring" means the observation by the Department, or the Department's designee, of a certified child foster home to determine continuing compliance with these rules.

(50) "Natural Supports" or "Natural Support System" means the resources available to an individual from the individual's relatives, friends, significant others, neighbors, roommates, and the community. Services provided by natural supports are resources that are not paid for by the Department.

(51) "Nurse" means a person who holds a current license from the Oregon Board of Nursing as a registered nurse (RN) or licensed practical nurse (LPN).

(52) "Nursing Care Plan" means the plan of care developed by a registered nurse that describes the medical, nursing, psychosocial, and other needs of a child and how those needs are met. The Nursing Care Plan includes the tasks that are taught or delegated to the foster provider and alternate caregivers.

(53) "Occupant" means any person having official residence in a certified child foster home.

(54) "Oregon Intervention System (OIS)" means the system of providing training to people who work with designated individuals to provide elements of positive behavior support and non-aversive behavior intervention. OIS uses principles of pro-active support and describes approved protective physical intervention techniques that are used to maintain health and safety.

(55) "Oregon Youth Authority (OYA)" means the agency that has been given commitment and supervision responsibilities over youth offenders, by order of the juvenile court under ORS 137.124 or other statute, until the time that a lawful release authority authorizes release or terminates the commitment or placement.

(56) "Permanent Foster Care" means the long term contractual agreement between a foster parent and the Department's Children, Adults, and Families Division, approved by the juvenile court that specifies the responsibilities and authority of the foster parent and the commitment by the permanent foster parent to raise a child until the age of majority or until the court determines that permanent foster care is no longer the appropriate plan for the child.

(57) "Protected Health Information" means any oral or written health information that identifies a child and relates to the child's past, present, or future physical or mental health condition, health care treatment, or payment for health care treatment.

(58) "Protective Physical Intervention" means any manual physical holding of, or contact with, a child that restricts the child's freedom of movement.

(59) "Psychotropic Medication" means medication the prescribed intent of which is to affect or alter thought processes, mood, or behavior including but not limited to anti-psychotic, antidepressant, anxiolytic (anti-anxiety), and behavior medications. The classification of a medication depends upon its stated, intended effect when prescribed.

(60) "Qualified Mental Health Professional" means a person who meets both of the following:

(a) Holds at least one of the following educational degrees:

(A) Graduate degree in psychology;

(B) Bachelor's degree in nursing and licensed in Oregon;

(C) Graduate degree in social work;

(D) Graduate degree in a behavioral science field;

(E) Graduate degree in recreational, art, or music therapy;

(F) Bachelor's degree in occupational therapy and licensed in Oregon; and

(b) Whose education and experience demonstrates the competencies to:

(A) Identify precipitating events;

(B) Gather histories of mental and physical disabilities, alcohol and drug use, past mental health services, and criminal justice contacts;

(C) Assess family, social, and work relationships;

(D) Conduct a mental status examination;

(E) Document a multiaxial DSM diagnosis;

(F) Write and supervise a Treatment Plan;

(G) Conduct a mental health assessment; and

(H) Provide individual, family, or group therapy within the scope of his or her practice.

(61) "Respite" means intermittent services provided on a periodic basis, but not more than 14 consecutive days, for the relief of, or due to the temporary absence of, a person normally providing supports to an individual unable to care for him or herself.

(62) "Revocation" means the action taken by the certifying agency to rescind a child foster home certificate of approval after determining that the child foster home is not in compliance with one or more of these rules.

(63) "Services Coordinator" means an employee of the Department, Community Developmental Disability Program, or other agency that contracts with the county or Department, who is selected to plan, procure, coordinate, monitor Individual Support Plan services, and to act as a proponent for individuals with intellectual or developmental disabilities.

(64) "Significant Medical Needs" means but is not limited to total assistance required for all activities of daily living such as access to food or fluids, daily hygiene that is not attributable to a child's chronological age, and frequent medical interventions required by a care plan for health and safety of a child.

(65) "Specialized Diet" means that the amount, type of ingredients, or selection of food or drink items is limited, restricted, or otherwise regulated under a physician's order. Examples include but are not limited to low calorie, high fiber, diabetic, low salt, lactose free, or low fat diets.

(66) "Substantiated" means an abuse investigation has been completed by the Department or the Department's designee and the preponderance of the evidence establishes the abuse occurred.

(67) "Suspension of Certificate" means a temporary withdrawal of the approval to operate a child foster home after the certifying agency determines that the child foster home is not in compliance with one or more of these rules.

(68) "Transfer" means movement of a child from one home to another home administered or operated by the same foster provider.

(69) "These Rules" mean the rules in OAR chapter 411, division 346.

(70) "Unauthorized Absence" means any length of time when a child is absent from a foster home without prior approval as specified in the child's Individual Support Plan.

(71) "Unusual Incident" means any incident involving a child that includes serious illness or accidents, death, injury or illness requiring inpatient or emergency hospitalization, suicide attempts, a fire requiring the services of a fire department, an act of physical aggression, or any incident requiring an abuse investigation.

(72) "Urgent Medical Need" means the onset of psychiatric symptoms requiring attention within 48 hours to prevent a serious deterioration in a child's mental or physical condition.

(73) "Variance" means the temporary exemption from a regulation or provision of these rules that may be granted by the Department upon written application by a certifying agency.

(74) "Volunteer" means any person assisting in a child foster home without pay to support the care provided to a child placed in the child foster home.

Stat. Auth.: ORS 409.050, 410.070, 430.215, & 443.835

Stats. Implemented: ORS 443.830 & 443.835

Hist.: MHD 15-2000(Temp), f. & cert. ef. 11-30-00 thru 5-28-01; MHD 3-2001, f. 5-25-01, cert. ef. 5-28-01; Renumbered from 309-046-0110, SPD 34-2004, f. 11-30-04, cert. ef. 1-1-05; SPD 10-2007, f. 6-27-07, cert. ef. 7-5-07; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 7-2010, f. 6-29-10, cert. ef. 7-1-10; SDP 6-2011(Temp), f. & cert. ef. 2-10-11 thru 8-1-11; SPD 15-2011, f. & cert. ef. 7-1-11; SPD 27-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

411-346-0180

Professional Responsibilities of the Foster Provider

(1) TRAINING AND DEVELOPMENT.

(a) The foster provider must complete a minimum of 15 hours of pre-service training prior to certification, and 10 hours annually for certification renewal. The Department or the certifier may require additional hours of training based on the needs of the child served in the home.

(b) The foster provider must participate in training provided or approved by the Department or the certifier. Such training must include educational opportunities designed to enhance the foster provider's awareness, understanding, and skills to meet the special needs of a child placed in their home.

(c) The foster provider must complete mandatory reporting training prior to initial certification and annually thereafter.

(d) Mandatory reporter training must be appropriate to the ages of the individuals living in the child foster home.

(2) RELATIONSHIP WITH THE CHILD PLACING AGENCY. The foster provider must:

(a) Take part in planning, preparation, pre-placement activities, and visitation for the child placed in their home;

(b) Participate as team members in developing and implementing the ISP when initiated by the CDDP services coordinator for the child placed in their home;

(c) In advance or within one working day, notify the certifier of changes likely to affect the life and circumstances of the foster family or the safety in the home including but not limited to the following:

(A) Foster family illness;

(B) Divorce, legal separation, or loss of a household member;

(C) Significant change in financial circumstances;

(D) New household members or placement of a child in foster care by another agency, including respite;

(E) Arrests or criminal involvement;

(F) The addition of hunting equipment and weapons;

(G) The addition of a swimming pool; or

(H) The addition of a pet.

(d) Immediately notify the child's CDDP services coordinator and guardian of a child's injury, illness, accidents, or any unusual incidents or circumstances that may have a serious effect on the health, safety, physical, or emotional well-being of the child in foster care;

(e) Notify the guardian and CDDP staff of any unauthorized absence of a child in foster care within 12 hours or other mutually agreed upon time as determined by the ISP team;

(f) Sign and abide by the responsibilities described in the Child Foster Home Contract;

(g) Allow the certifier and child placing agency reasonable access to their home and to the child placed in their care. This includes access by a child's family members when placement is voluntary. For the purpose of these rules, reasonable access means with prior notice unless there is cause for not giving such notice;

(h) Allow the Department or certifying agency staff access to:

(A) Investigate reports of abuse, violations of a regulation, or provision of these rules;

(B) Inspect or examine the home, the child's records and accounts, and the physical premises including the buildings, grounds, equipment, and any vehicles; and

(C) Interview the child, adult, or alternate caregivers.

(i) Participate in interviews conducted by the Department or the certifier; and

(j) Authorize substitute caregivers to permit entrance by the Department or the certifier for the purpose of inspection and investigation.

(3) ACCEPTING CHILDREN FOR CARE.

(a) Except as described in section (3)(c) of this rule, a certified provider may not exceed the following maximum number of children in the foster home including the provider's biological children:

(A) A total of four children when one certified adult lives in the home; or

(B) A total of seven children when two certified adults live in the home.

(b) All homes are limited to two children under the age of three.

(c) Any providers certified prior to July 1, 2007 with a capacity greater than the numbers listed in section (3)(a) of this rule must meet the standard through attrition as children move out of the foster home.

(d) Any child foster home provider contracted by a proctor agency to provide proctor care services is limited to serving a total of two children in foster care.

(e) At the time of referral, the foster provider must be given available information about the child, including behavior, skill level, medical status, and other relevant information. The foster provider is obligated to decline the referral of any child based on the referral information, parameters of their certification, or if they feel their skill level may not safely or effectively support the child.

(f) A foster provider may provide respite in the provider's home for a child upon approval by the certifier or the Department.

(g) A foster provider must obtain approval from the certifier prior to accepting a child for placement.

(h) A child who turns 18 may continue to reside in their current certified child foster home when it has been determined by the ISP team it is in the best interest of the child to remain in the same home. When it has been determined by the ISP team a child who is turning 18 may remain in their current certified child foster home the foster provider must:

(A) Submit a variance request to the Department in accordance with OAR 411-346-0210; and

(B) Submit to the Department and the certifier, a copy of the ISP addendum signed by the ISP team noting it is in the best interest of the child to remain in the current certified foster home.

(i) Any variance to sections (3)(a), through (3)(h) of this rule must take into consideration the maximum safe physical capacity of the home including:

(A) Sleeping arrangements;

(B) The ratio of adult to child;

(C) The level of supervision available;

(D) The skill level of the foster provider;

(E) Individual plans for egress during fire;

(F) The needs of the other children in placement; and

(G) The desirability of keeping siblings placed together.

(j) The foster provider may not care for unrelated adults on a commercial basis in their own home or accept children for day care in their own home while currently certified as a foster provider.

(k) The foster provider must notify the Department prior to a voluntary closure of a child foster home, and give the child's guardian and the CDDP 30 day's written notice, except in circumstances where undue delay might jeopardize the health, safety, or well-being of the child or foster provider.

(4) INVOLUNTARY TRANSFERS AND EXITS.

(a) A foster provider may only transfer or exit a child involuntarily for one or more of the following reasons:

(A) To protect the health, safety, and welfare of the child or others in the home;

(B) The child's service needs exceed the ability of the foster provider;

(C) Failure to pay for services; or

(D) The foster provider's certification is suspended, revoked, not renewed, or voluntarily surrendered.

(b) NOTICE OF INVOLUNTARY EXIT. A foster provider may not transfer or exit a child involuntarily without 30 days advance written notice to the child's guardian, and the CDDP services coordinator except in the case of a medical emergency or when a child is engaging in behavior that poses an imminent danger to self or others in the home as described in subsection (c) of this section.

(A) The written notice must be provided on a form approved by the Department (form SDS 0719) and include:

(i) The reason for the transfer or exit; and

(ii) The right to a hearing as described in subsection (e) of this section.

(B) A notice is not required when a child's guardian requests a transfer or exit.

(c) A foster provider may give less than 30 days advanced written notice only in a medical emergency or when a child is engaging in behavior that poses an imminent danger to self or others in the home. The notice must be provided to the child's guardian and CDDP services coordinator immediately upon determination of the need for a transfer or exit.

(d) A foster provider is responsible for the provision of services until a child exits the home.

(e) HEARING RIGHTS. A child and the child's guardian must be given the opportunity for a contested case hearing under ORS 183 to dispute an involuntary transfer or exit. If a child or the child's guardian requests a hearing, the child must receive the same services until the hearing is resolved. When a child has been given less than 30 days advanced written notice of a transfer or exit as described in subsection (c) of this section and the child or the child's guardian has requested a hearing, the foster provider must reserve the child's room until receipt of the Final Order.

(5) RELATIONSHIP WITH THE CHILD'S FAMILY. In accordance with the child's ISP and the guardian, the foster provider must:

(a) Support the child's relationship with the child's family members including siblings;

(b) Assist the CDDP staff and the guardian in planning visits with the child and the child's family members; and

(c) Provide the child reasonable opportunities to communicate with their family members.

(6) CONFIDENTIALITY.

(a) The foster provider and the provider's family must treat personal information about a child or a child's family in a confidential manner. Confidential information is to be disclosed on a need to know basis to law enforcement, certifying agency staff, CDDP staff, DHS-CW child protective services staff, DHS-CW case workers, and medical professionals who are treating or providing services to the child. The information shared must be limited to the health, safety, and service needs of the child.

(b) In addition to the requirements in section (5)(a) of this rule, the foster provider and the provider's family must comply with the provisions of ORS 192.518 to 192.523 and therefore may use or disclose a child's protected health information only:

(A) To law enforcement, certifying agency staff, CDDP staff, and DHS-CW staff;

(B) As authorized by the child's personal representative or guardian appointed under ORS 125.305, 419B.370, 419C.481, or 419C.555;

(C) For purposes of obtaining health care treatment for the child;

(D) For purposes of obtaining payment for health care treatment; or

(E) As permitted or required by state or federal law or by order of a court.

(c) The foster provider must keep all written records for each child in a manner that ensures their confidentiality.

(7) MANDATORY REPORTING.

(a) The foster provider and their employees and volunteers are mandatory reporters of suspected abuse of any child as defined by ORS 419B.005. Upon reasonable cause to believe that abuse has occurred, all adult members of the household and any foster provider, employees, independent contractors, or volunteers must report pertinent information to DHS-CW or law enforcement.

(b) When the certified child foster provider, their employees, independent contractors, or volunteers are providing services to an individual 18 years or older and have reason to believe abuse as defined in OAR 407-045-0260 has occurred, they must report the pertinent information to the CDDP or law enforcement in accordance with ORS 430.737.

(c) Any protective physical intervention that results in an injury to the child, as defined in ORS 419B.005, must be reported by the foster provider. Same day verbal notification is required. The foster provider must notify DHS-CW and the child's CDDP services coordinator.

Stat. Auth.: ORS 409.050, 410.070, 430.215, & 443.835
Stats. Implemented: ORS 443.830 & 443.835
Hist.: MHD 15-2000(Temp), f. & cert. ef. 11-30-00 thru 5-28-01; MHD 3-2001, f. 5-25-01, cert. ef. 5-28-01; Renumbered from 309-046-0180, SPD 34-2004, f. 11-30-04, cert. ef. 1-1-05; SPD 10-2007, f. 6-27-07, cert. ef. 7-5-07; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 7-2010, f. 6-29-10, cert. ef. 7-1-10; SPD 27-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

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Rule Caption: Medically Fragile Children Services
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Notice Publication Date:
Rules Amended: 411-350-0020, 411-350-0030, 411-350-0040, 411-350-0050

Subject: The Department of Human Services (Department) is immediately amending the rules for medically fragile children services in OAR chapter 411, division 350 to:

Reflect new definitions applicable to Community First Choice State Plan services;

Specify the eligibility requirements to reflect changes made as a result of the Community First Choice State Plan;

Describe and coincide with the services available in the Community First Choice State Plan and Home and Community-Based Waiver amendments;

Require a functional needs assessment as part of a child's service planning process; and

Clarify the responsibilities of a services coordinator when developing a child's Plan of Care.

Rules Coordinator: Christina Hartman—(503) 945-6398

411-350-0020

Definitions

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 350:

(1) "Abuse" means abuse of a child as defined in ORS 419B.005.

(2) "Activities of Daily Living (ADL)" mean those personal, functional activities required by a child for continued well-being that are essential for health and safety.

(3) "Aide" means a nonlicensed caregiver who may or may not be a certified nursing assistant.

(4) "Background Check" means a criminal records check and abuse check as defined in OAR 407-007-0210 (Criminal Records and Abuse Check for Providers).

(5) "Behavior Support Plan (BSP)" means a written strategy based on person-centered planning and a functional assessment that outlines specific instructions for a provider to follow, to cause a child's challenging behaviors to become unnecessary, and to change the provider's own behavior, adjust environment, and teach new skills.

(6) "Billing Provider" means an organization that enrolls and contracts with the Department to provide services through an employee and bills the Department for the provider's services.

(7) "Child" means an individual who is less than 18 and applying for or eligible for medically fragile children services.

(8) "Chore Services" mean the services described in OAR 411-350-0050 needed to maintain a clean, sanitary, and safe environment in a child's home. Chore services include heavy household chores such as washing floors, windows, and walls, tacking down loose rugs and tiles, and moving heavy items of furniture for safe access and egress. Chore services may include yard hazard abatement to ensure the outside of the home is safe for the child to traverse and enter and exit the home.

(9) "Clinical Criteria (Form DHS-0519)" means the assessment tool used by the Department to evaluate the intensity of the challenges and care needs of medically fragile children.

(10) "Community First Choice State Plan" means Oregon's state plan amendment authorized under section 1915(k) of the Social Security Act.

(11) "Community Nursing Services" mean the services described in OAR 411-350-0050 that include nurse delegation and care coordination for a child living in his or her own home. Community nursing services do not include direct nursing care and are not covered by other Medicaid spending authorities

(12) "Cost Effective" means that in the opinion of the services coordinator, a specific service meets the child's service needs and costs less than, or is comparable to, other similar service options considered.

(13) "Delegation" means that a registered nurse authorizes an unlicensed person to perform nursing tasks and confirms that authorization in writing. Delegation may occur only after the registered nurse follows all steps of the delegation process as outlined in OAR chapter 851, division 047. Delegation by physicians is also allowed.

(14) "Department" means the Department of Human Services (DHS). The term "Department" is synonymous with "Seniors and People with Disabilities Division (Division)".

(15) "Developmental Disability (DD)" means a neurological condition that originates in the developmental years, that is likely to continue, and significantly impacts adaptive behavior as diagnosed and measured by a qualified professional as described in OAR 411-320-0080.

(16) "Director" means the Director of the Department's Office of Developmental Disability Services or the Director's designee.

(17) "Environmental Accessibility Adaptations" mean the physical adaptations as described in OAR 411-355-0050 that are necessary to ensure the health, welfare, and safety of a child in the home, or that enable the child to function with greater independence in the home.

(18) "Family Home" means the residence of a child that may, for the purpose of these rules, include a certified foster home.

(19) "Family Training" means training and counseling services for the family of a child that increase the family's capacity to care for, support, and maintain the child in the home as described in OAR 411-300-0150.

(a) Family training includes:

(A) Instruction about treatment regimens and use of equipment specified in the child's Plan of Care;

(B) Information, education, and training about the child's intellectual or developmental disability, medical, or behavioral conditions; and

(C) Counseling for the family to relieve the stress associated with caring for a child with an intellectual or developmental disability.

(b) To determine who may receive family training, family means a unit of two or more persons that include at least one child with an intellectual or developmental disability where the primary caregiver is:

(A) Related to the child by blood, marriage, or legal adoption; or

(B) In a domestic relationship where partners share:

(i) A permanent residence;

(ii) Joint responsibility for the household in general (e.g. child-rearing, maintenance of the residence, basic living expenses); and

(iii) Joint responsibility for supporting the child and the child is related to one of the partners by blood, marriage, or legal adoption.

(20) "Founded Reports" means the Department's Children, Adults, and Families Division or Law Enforcement Authority (LEA) determination, based on the evidence, that there is reasonable cause to believe that conduct in violation of the child abuse statutes or rules has occurred and such conduct is attributable to the person alleged to have engaged in the conduct.

(21) "Functional Needs Assessment (FNAT)" means an assessment that documents the level of need, accommodates a child's participation in service planning, and includes --

(a) Completing a comprehensive and holistic assessment;

(b) Surveying physical, mental, and social functioning; and

(c) Identifying risk factors, choices and preferences, and service needs.

(22) "Home and Community-Based Waivered Services" mean the services approved by the Centers for Medicare and Medicaid Services in accordance with Section 1915(c) and 1115 of the Social Security Act.

(23) "Grievance" means a process by which a person may air complaints and seek remedies.

(24) "Hospital Model Waiver" means the waiver program granted by the federal Centers for Medicare and Medicaid Services that allows Title XIX funds to be spent on children living in the family home who otherwise would have to be served in a hospital if the waiver program was not available.

(25) "In-Home Daily Care (IHDC)" means Medicaid state plan funded essential supportive daily care as described in OAR 411-350-0050 delivered by a qualified provider that enables a child to remain, or return to, the family home.

(26) "Instrumental Activities of Daily Living (IADL)" mean those activities, other than activities of daily living, required to continue independent living.

(27) "Intellectual Disability" has the meaning set forth in OAR 411-320-0020 and described in OAR 411-320-0080.

(28) "Level of Care" means an assessment completed by a services coordinator has determined a child meets institutional level of care. A child meets institutional level of care for hospital level of care for children with intellectual or developmental disabilities if --

(a) A child has a documented medical condition and demonstrates the need for active treatment as assessed by the clinical criteria as defined in OAR 411-350-0020.

(b) A child's medical condition requires the care and treatment of services normally provided in an acute medical hospital.

(29) "Mandatory Reporter" means any public or private official as defined in OAR 407-045-0260 who comes in contact with and has reasonable cause to believe a child with or without an intellectual or developmental disability has suffered abuse, or comes in contact with any person whom the official has reasonable cause to believe abused a child, regardless of whether or not the knowledge of the abuse was gained in the reporter's official capacity. Nothing contained in ORS 40.225 to 40.295 affects the duty to report imposed by this section, except that a psychiatrist,

psychologist, clergy, attorney, or guardian ad litem appointed under ORS 419B.231 is not required to report such information communicated by a person if the communication is privileged under ORS 40.225 to 40.295.

(30) "Medicaid Fair Hearing" means the formal process following an action that would terminate, suspend, reduce, or deny a Medicaid service. This is a formal process required by federal law (42 CFR 431.200-250). A Medicaid Fair Hearing is also known as a contested case hearing.

(31) "Medically Fragile Children (MFC)" means children, who have a health impairment that requires long term, intensive, specialized services on a daily basis and who have been found eligible for medically fragile children services by the Department.

(32) "Medically Fragile Children's Unit (MFCU)" means the program for medically fragile children administered by the Department.

(33) "MFC" means "Medically Fragile Children" as defined in this rule.

(34) "Natural Supports" or "Natural Support System" means the resources available from relatives, friends, significant others, neighbors, roommates, and the community. Services provided by natural supports are resources that are not paid for by the Department.

(35) "Nurse" means a person who holds a current license from the Oregon Board of Nursing as a registered nurse (RN) or licensed practical nurse (LPN) pursuant to ORS chapter 678.

(36) "Nursing Care Plan" means a plan of care developed by a nurse that describes the medical, nursing, psychosocial, and other needs of a child, and how those needs are met. The Nursing Care Plan includes the tasks that are taught or delegated to the qualified provider or primary caregiver. When a Nursing Care Plan exists, it becomes a part of the Plan of Care.

(37) "Nursing Tasks or Services" mean the care or services that require the education and training of a licensed professional nurse to perform. Nursing tasks or services may be delegated.

(38) "OHP" means the Oregon Health Plan.

(39) "Oregon Intervention System (OIS)" means a system of providing training to people who work with designated individuals to intervene physically or non-physically to keep individuals from harming self or others. OIS is based on a positive approach that includes methods of effective evasion, deflection, and escape from holding.

(40) "OSIP-M" means Oregon Supplemental Income Program-Medical as defined in OAR 461-101-0010. OSIP-M is Oregon Medicaid insurance coverage for those who meet the eligibility criteria as described in OAR chapter 461.

(41) "Parent" means biological parent, adoptive parent, stepparent, or legal guardian.

(42) "Person-Centered Planning" means:

(a) A process, either formal or informal, for gathering and organizing information that helps:

(A) Determine and describe choices about personal goals, activities, and lifestyle preferences;

(B) Design strategies and networks of support to achieve goals and a preferred lifestyle using strengths, relationships, and resources; and

(C) Identify, use, and strengthen naturally occurring opportunities for support at home and in the community.

(b) The methods for gathering information vary, but all are consistent with a child's needs and preferences.

(43) "Personal Care Services" means assistance with activities of daily living, instrumental activities of daily living, and health-related tasks through cueing, monitoring, reassurance, redirection, set-up, hands-on, standby assistance, and reminding.

(44) "Plan of Care" means the written details of the supports, activities, and resources required for a child to achieve personal outcomes. Individual support needs are identified through a functional needs assessment. The manner in which services are delivered, service providers, and the frequency of services are reflected in a Plan of Care. The Plan of Care is developed at minimum annually to reflect decisions and agreements made during a person-centered process of planning and information gathering. The Plan of Care includes a Nursing Care Plan when one exists. The Plan of Care reflects whether services are provided through a waiver, state plan, or through a child's natural supports.

(45) "Positive Behavioral Theory and Practice" means a proactive approach to behavior and behavior interventions that:

(a) Emphasizes the development of functional alternative behavior and positive behavior intervention;

(b) Uses the least intervention possible;

(c) Ensures that abuse or demeaning interventions are never used; and

(d) Evaluates the effectiveness of behavior interventions based on objective data.

(46) "Primary Caregiver" means the parent or foster provider that provides the direct care of the child at the times that a paid provider is not available.

(47) "Provider or Performing Provider" means a person who meets the requirements of OAR 411-350-0080 that is qualified to receive payment from the Department for in-home daily care. Providers work directly with medically fragile children. Providers may be employees of billing providers, employees of a child's parent, or independent contractors.

(48) "Respite" means intermittent services as described in OAR 411-300-0150 provided on a periodic basis, but not more than 14 consecutive days, for the relief of, or due to the temporary absence of a child's primary caregiver.

(49) "Service Budget" means the monthly dollar amount allotted for the care of the child based on the clinical criteria. The service budget consists of in-home daily care and, if the child is on a waiver, waivered services. Service budgets increase or decrease in direct relationship to the increasing or decreasing clinical criteria score.

(50) "Services Coordinator" means an employee of the Department who ensures a child's eligibility for medically fragile children services and provides assessment, case management, service implementation, and evaluation of the effectiveness of the services.

(51) "Specialized Diet" means specially prepared or particular types of food needed to sustain a child in the family home as described in OAR 411-350-0050.

(52) "Specialized Equipment and Supplies" mean devices, aids, controls, supplies, or appliances as described in OAR 411-300-0150 that meet applicable standards of manufacture, design, and installation that enable children to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. Specialized equipment and supplies do not include items not of direct benefit to a child.

(53) "Substantiated" means an abuse investigation has been completed by the Department or the Department's designee and the preponderance of the evidence establishes the abuse occurred.

(54) "Supplant" means take the place of.

(55) "These Rules" mean the rules in OAR chapter 411, division 350.

(56) "Transportation" means services as described in OAR 411-300-0150 that allow a child to gain access to community services, activities, and resources that are not medical in nature.

(57) "Volunteer" means any person providing services without pay to support the services provided to a child.

(58) "Waivered Services" mean a menu of disability related services and supplies, beyond in-home daily care and the Oregon Health Plan, that are specifically identified by the Title XIX Centers for Medicare and Medicaid Services Waiver.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 427.005, 427.007 & 430.215
Hist.: MHD 21-1998(Temp), f. 11-25-98, cert. ef. 12-1-98 thru 5-29-99; MHD 3-1999, f. 5-17-99, cert. ef. 5-28-99; MHD 8-2003(Temp) f. & cert. ef. 12-11-03 thru 6-7-04; Renumbered from 309-044-0110, SPD 14-2004, f. & cert. ef. 6-1-04; SPD 1-2009, f. 2-24-09, cert. ef. 3-1-09; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 5-2010, f. 6-29-10, cert. ef. 7-1-10; SPD 28-2013(Temp), f. & cert. ef. 7-2-13 thru 12-29-13

411-350-0030
Eligibility

(1) ELIGIBILITY. In order to be eligible for MFC services, a child must:

(a) Be under the age of 18;

(b) Be a U.S. citizen;

(c) Be eligible for OSIP-M;

(d) Be eligible to receive Title XIX (Medicaid) or Title XXI (CHIPS) services;

(e) Be accepted by the Department by scoring 50 or greater on the clinical criteria and have a status of medical need that is likely to last for more than two months;

(f) After completion of an assessment, meet the level of care defined in OAR 411-350-0020;

(g) Reside in the family home; and

(h) Be capable of being safely served in the family home. This includes, but is not limited to, the primary caregiver demonstrating the willingness, skills, and ability to provide the direct care, not paid for in the plan of care, as determined by the service coordinator within the limitations of OAR 411-350-0050.

(2) INELIGIBILITY. A child is not eligible for MFC services if the child:

(a) Resides in a hospital, school, sub-acute facility, nursing facility, intermediate care facility, residential facility, or other institution;

(b) Does not require waivered services, Community First Choice State Plan services, or has sufficient family, government, or community resources available to provide for his or her care; or

(c) Is not safely served in the family home as described in section (1)(h) of this rule.

(3) REDETERMINATION. The Department redetermines a child's eligibility for MFC services using the clinical criteria at a minimum of every six months, or as the child's status changes.

(4) TRANSITION. A child who meets the following criteria must begin a transition period to phase out of MFC services within 60 days and at the end of the 60 days transition period, is no longer eligible to receive MFC services:

(a) The child has been previously eligible for MFC services;

(b) The needs of the child have decreased; and

(c) The score on the clinical criteria remains at less than 30 during the transition period.

(5) WAIT LIST. The Department may place a child eligible for MFC services on a wait list, based on the date of referral, if the allowable numbers of children on the Hospital Model Waiver are already being served. State plan services are available for a child with Medicaid services in place.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 427.005, 427.007 & 430.215
Hist.: MHD 21-1998(Temp), f. 11-25-98, cert. ef. 12-1-98 thru 5-29-99; MHD 3-1999, f. 5-17-99, cert. ef. 5-28-99; MHD 8-2003(Temp) f. & cert. ef. 12-11-03 thru 6-7-04; Renumbered from 309-044-0120, SPD 14-2004, f. & cert. ef. 6-1-04; SPD 1-2009, f. 2-24-09, cert. ef. 3-1-09; SPD 28-2013(Temp), f. & cert. ef. 7-2-13 thru 12-29-13

411-350-0040
Plan of Care

(1) To develop the plan of care, the service coordinator must complete an FNAT using a person-centered planning approach and assess the service needs of the child. The assessment must take place in person and the services coordinator must interview the child's parent, other caregivers, or when appropriate, others interested individuals. The assessment must identify:

(a) The services for which the child is currently eligible;

(b) The services currently being provided; and

(c) All available family, community, private health insurance, and government or community resources that meet any, some, or all of the child's needs.

(2) The services coordinator must prepare, with the input of the parent and any other person at the parent's request, a written Plan of Care that identifies:

(a) The service needs of the child and the child's family;

(b) The most cost effective services for safely and appropriately meeting the child's service needs; and

(c) The methods, resources, and strategies that address some or all of the child's service needs.

(3) The service coordinator must prepare a Plan of Care that includes:

(a) A description of the supports required, including the reason the support is necessary. For an initial or annual Plan of Care that is authorized after July 1, 2013, the description must be consistent with the FNAT;

(b) A list of personal, community, and public resources that are available to the child and how the resources may be applied to provide the required supports. Sources of support may include waivered or state plan services, state general funds, or natural supports;

(c) The maximum hours of authorized provider services;

(d) The annual service level;

(e) The number of hours of MFC services authorized for the child;

(f) Additional services authorized by the Department for the child;

(g) The estimated number of hours that an aide is authorized and the number of hours that a licensed nurse is authorized;

(A) RN hours may not be authorized when an LPN can safely perform the duties.

(B) RN or LPN hours may not be authorized when an aide can safely perform the duties.

(h) The date of the next Plan of Care review that, at a minimum, must be completed within 12 months of the last Plan of Care or more frequently if the child's medical status changes; and

(i) The child's Nursing Care Plan, when one exists.

(4) The parent must review the Plan of Care prior to implementation.

(5) The parent and the services coordinator must sign the Plan of Care and a copy must be provided to the parent.

(6) The services coordinator must reflect significant changes in the needs of the child in the Plan of Care, as they occur, and provide a copy of the revised Plan of Care to the parent.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 427.005, 427.007 & 430.215
Hist.: MHD 21-1998(Temp), f. 11-25-98, cert. ef. 12-1-98 thru 5-29-99; MHD 3-1999, f. 5-17-99, cert. ef. 5-28-99; MHD 8-2003(Temp) f. & cert. ef. 12-11-03 thru 6-7-04; Renumbered from 309-044-0130, SPD 14-2004, f. & cert. ef. 6-1-04; SPD 1-2009, f. 2-24-09, cert. ef. 3-1-09; SPD 28-2013(Temp), f. & cert. ef. 7-2-13 thru 12-29-13

411-350-0050
Scope and Limitations of MFC Services

(1) MFC services are intended to support, not supplant, the natural supports supplied by a primary caregiver. Regardless of other services available, a primary caregiver must provide a minimum of 40 hours per week of in home daily care for the child. MFC services are not available to replace services provided by the primary caregiver or to replace other governmental or community services.

(2) For an initial or annual Plan of Care that is authorized on or after July 1, 2013, medically fragile children services may include a combination of the following waivered and other Medicaid services based upon the needs of a child as determined by the services coordinator and as consistent with the child's Plan of Care:

(a) Community First Choice State Plan services:

(A) Specialized consultation including behavior consultation as described in section (3) of this rule;

(B) Community nursing services as described in section (4) of this rule;

(C) Environmental accessibility adaptations as described in section (5) of this rule;

(D) In-home daily care as described in section (6) of this rule;

(E) Respite as described in section (7) of this rule;

(F) Specialized equipment and supplies as described in section (8) of this rule;

(G) Chore services as described in section (9) of this rule; and

(H) Transportation as described in section (10) of this rule.

(b) Waivered services:

(A) Family training as described in section (11) of this rule;

(B) Specialized diets as described in section (12) of this rule; and

(C) Translation as described in section (13) of this rule.

(3) SPECIALIZED CONSULTATION — BEHAVIOR CONSULTATION. Behavior consultation is only authorized to support a primary caregiver in their caregiving role. Behavior consultation is only authorized, as needed, to respond to specific problems identified by a primary caregiver or services coordinator. Behavior consultants must:

(a) Work with the primary caregiver to identify:

(A) Areas of a child's family home life that are of most concern for the parent and child;

(B) The formal or informal responses the family or provider has used in those areas; and

(C) The unique characteristics of the family that may influence the responses that may work with the child.

(b) Assess the child. The assessment must include:

(A) Specific identification of the behaviors or areas of concern;

(B) Identification of the settings or events likely to be associated with, or to trigger, the behavior;

(C) Identification of early warning signs of the behavior;

(D) Identification of the probable reasons that are causing the behavior and the needs of the child that are being met by the behavior, including the possibility that the behavior is:

(i) An effort to communicate;

(ii) The result of a medical condition;

(iii) The result of an environmental cause; or

(iv) The symptom of an emotional or psychiatric disorder.

(E) Evaluation and identification of the impact of disabilities (i.e. autism, blindness, deafness, etc.) that impact the development of strategies and affect the child and the area of concern; and

(F) An assessment of current communication strategies.

(c) Develop a variety of positive strategies that assist the primary caregiver and provider to help the child use acceptable, alternative actions to meet the child's needs in the most cost effective manner. These strategies may include changes in the physical and social environment, developing effective communication, and appropriate responses by a primary caregiver and provider to the early warning signs.

(A) Positive, preventive interventions must be emphasized.

(B) The least intrusive intervention possible must be used.

(C) Abusive or demeaning interventions must never be used.

(D) The strategies must be adapted to the specific disabilities of the child and the style or culture of the family.

(d) Develop emergency and crisis procedures to be used to keep the child, primary caregiver, and provider safe. When interventions in the behavior of the child are necessary, positive, preventative, non-aversive interventions that conform to OIS must be utilized.

(e) Develop a written Behavior Support Plan that includes the following:

(A) Use of clear, concrete language that is understandable to the primary caregiver and provider; and

(B) Describes the assessment, strategies, and procedures to be used.

(f) Teach the provider and primary caregiver the strategies and procedures to be used.

(g) Monitor and revise the Behavior Support Plan as needed.

(4) COMMUNITY NURSING SERVICES.

(a) Evaluation and identification of supports that minimize health risks, while promoting the child's autonomy and self-management of healthcare;

(b) Medication reviews;

(c) Collateral contact with the services coordinator regarding the child's community health status to assist in monitoring safety and well-being and to address needed changes to the person-centered Plan of Care; and

(d) Delegation of nursing tasks to a provider and primary caregiver so that caregivers may safely perform health related tasks.

(5) ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS. Environmental accessibility adaptations are physical adaptations to a family home that are necessary to ensure the health, welfare, and safety of the child in the family home due to the child's intellectual or developmental disability or that are necessary to enable the child to function with greater independence around the family home and in family activities.

(a) Environmental accessibility adaptations include but are not limited to:

(A) An environmental modification consultation to determine the appropriate type of adaptation to ensure the health, welfare, and safety of the child;

(B) Installation of shatter-proof windows;

(C) Hardening of walls or doors;

(D) Specialized, hardened, waterproof, or padded flooring;

(E) An alarm system for doors or windows;

(F) Protective covering for smoke detectors, light fixtures, and appliances;

(G) Sound and visual monitoring systems;

(H) Fencing;

(I) Installation of ramps, grab-bars, and electric door openers;

(J) Adaptation of kitchen cabinets and sinks;

(K) Widening of doorways;

(L) Handrails;

(M) Modification of bathroom facilities;

(N) Individual room air conditioners for a child whose temperature sensitivity issues create behaviors or medical conditions that put the child or others at risk;

(O) Installation of non-skid surfaces;

(P) Overhead track systems to assist with lifting or transferring;

(Q) Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the child;

(R) Modifications for the primary vehicle used by the child that are necessary to meet the unique needs of the child and ensure the health, welfare, and safety of the child (lift or interior alterations such as seats, head, and leg rests; and belts, special safety harnesses, or other unique modifications to keep the child safe in the vehicle); and

(S) Adaptations to control lights, heat, stove, etc.

(b) Environmental accessibility adaptations exclude:

(A) Adaptations or improvements to the family home that are of general utility and are not for the direct safety, remedial, or long term benefit to the child;

(B) Adaptations that add to the total square footage of the family home; and

(C) General repair or maintenance and upkeep required for the family home or motor vehicle, including repair of damage caused by the child.

(c) Environmental modifications are limited to $5,000 per modification. A services coordinator may request approval for additional expenditures through the Department prior to expenditure. Approval is based on the child's service needs and goals and the Department's determination of appropriateness and cost-effectiveness.

(d) Environmental modifications must be tied to supporting activities of daily living, instrumental activities of daily living, and health-related tasks as identified in the Plan of Care.

(e) Modifications over $500 must be completed by a state licensed contractor. Any modification requiring a permit must be inspected and be certified as in compliance with local codes by local inspectors and filed in provider file prior to payment. Environmental modifications must be made within the existing square footage of the family home, except for external ramps, and cannot add to the square footage of the building. Payment to the contractor is to be withheld until the work meets specifications.

(f) Environmental accessibility adaptations that are provided in a rental structure must be authorized in writing by the owner of the structure prior to initiation of the work. This does not preclude any reasonable accommodations required under the Americans with Disabilities Act.

(6) IN-HOME DAILY CARE. In-home daily care services include the purchase of direct provider support provided to a child in the family home or community by qualified individual providers and agencies. Provider assistance provided through in-home daily care must support the child to live as independently as appropriate for the child's age and must be based on the identified needs of the child, supporting the family in a primary caregiving role. Primary caregivers are expected to be present or immediately available during the provision of in-home daily care.

(a) In-home daily care services provided by qualified providers or agencies include:

(A) Basic personal hygiene — Assistance with bathing and grooming;

(B) Toileting, bowel, and bladder care — Assistance in the bathroom, diapering, external cleansing of perineal area, and care of catheters;

(C) Mobility — Transfers, comfort, positioning, and assistance with range of motion exercises;

(D) Nutrition — feeding and monitoring intake and output;

(E) Skin care — Dressing changes;

(F) Physical healthcare including delegated nursing tasks;

(G) Supervision — Providing an environment that is safe and meaningful for the child and interacting with the child to prevent danger to the child and others, and maintain skills and behaviors required to live in the home and community;

(H) Assisting the child with appropriate leisure activities to enhance development in the family home and community and provide training and support in personal environmental skills;

(I) Communication — Assisting the child in communicating, using any means used by the child;

(J) Neurological — Monitoring of seizures, administering medication, and observing status; and

(K) Accompanying the child and family to health related appointments.

(b) In-home daily care services must:

(A) Be previously authorized by the services coordinator before services begin;

(B) Be delivered through the most cost effective method as determined by the services coordinator; and

(C) Only be provided when the child is present to receive services.

(c) In-home daily care services exclude:

(A) Hours that supplant the natural supports and services available from family, community, other government or public services, insurance plans, schools, philanthropic organizations, friends, or relatives;

(B) Hours to allow a primary caregiver to work or attend school;

(C) Support generally provided at the child's age by parents or other family members;

(D) Educational and supportive services provided by schools as part of a free and appropriate education for children and young adults under the Individuals with Disabilities Education Act;

(E) Services provided by the family; and

(F) Home schooling.

(d) In-home daily care services may not be provided on a 24-hour shift-staffing basis. The child's primary caregiver is expected to provide at least 40 hours of care each week and supervise the child each day with the exception of overnight respite. The 40 hours of care and supervision may not include hours when the child's primary caregiver is sleeping.

(7) RESPITE. Respite services are provided to a child on a periodic or intermittent basis furnished because of the temporary absence of, or need for relief of, the primary caregiver.

(a) Respite may include both day and overnight services that may be provided in:

(A) The family home;

(B) A licensed, certified, or otherwise regulated setting;

(C) A qualified provider's home. If overnight respite is provided in a qualified provider's home, the services coordinator and the child's parent must document that the home is a safe setting for the child; or

(D) A disability-related or therapeutic recreational camp.

(b) The services coordinator does not authorize respite services:

(A) To allow primary caregivers to attend school or work;

(B) That are ongoing and occur on more than a periodic schedule, such as eight hours a day, five days a week;

(C) On more than 14 consecutive overnight stays in a calendar month;

(D) For more than 10 days per individual plan year when provided at a specialized camp;

(E) For vacation travel and lodging expenses; or

(F) To pay for room and board if provided at a licensed site or specialized camp.

(8) SPECIALIZED EQUIPMENT AND SUPPLIES. Specialized equipment and supplies include the purchase of devices, aids, controls, supplies, or appliances that are necessary to enable a child to increase the child's abilities to perform and support activities of daily living, or to perceive, control, or communicate with the environment in which the child lives.

(a) Electronic devices to secure assistance in an emergency in the community and other reminders such as medication minders and alert systems for ADL/IADL supports, or mobile electronic devices. Expenditures for electronic devices of more than $500 in a plan year require Department approval.

(b) Assistive technology to provide additional security and replace the need for direct interventions to allow self direction of care and maximize independence. Examples include motion sound sensors, two-way communication systems, automatic faucets and soap dispensers, incontinent and fall sensors, or other electronic backup systems.

(A) Limit of $5000 per year without Department approval.

(B) Any single device or assistance costing more than $500 must be approved by the Department.

(c) Assistive devices. Examples include durable medical equipment, mechanical apparatus, electrical appliance or information technology device to assist and enhance an individual's independence in performing ADL/IADLs, not covered by other Medicaid programs. Limit of $5000 per year without Department approval. Any single device or assistance costing more than $500 must be approved by the department.

(d) The purchase of specialized equipment and supplies may include the cost of a professional consultation, if required, to assess, identify, adapt, or fit specialized equipment. The cost of professional consultation may be included in the purchase price of the equipment.

(e) To be authorized by the services coordinator, specialized equipment and supplies must be:

(A) In addition to any medical equipment and supplies furnished under the Oregon Health Plan and private insurance;

(B) Determined necessary to the daily functions of the child; and

(C) Directly related to a child's disability.

(f) Specialized equipment and supplies exclude:

(A) Items that are not necessary or of direct medical or remedial benefit to the child;

(B) Specialized equipment and supplies intended to supplant similar items furnished under the Oregon Health Plan or private insurance;

(C) Items available through family, community, or other governmental resources;

(D) Items that are considered unsafe for a child;

(E) Toys or outdoor play equipment; and

(F) Equipment and furnishings of general household use.

(g) Funding for specialized equipment with an expected life of more than one year is one time funding that is not continued in subsequent plan years. Specialized equipment may only be included in a child's annual Plan of Care when all other public and private resources for the equipment have been exhausted.

(h) The services coordinator must secure use of equipment or furnishings costing more than $500 through a written agreement between the Department and the child's parent that specifies the time period the item is to be available to the child and the responsibilities of all parties if the item is lost, damaged, or sold within that time period. Any equipment or supplies purchased with MFC funds that are not used according to the child's annual Plan of Care, or according to the written agreement between the Department and the child's parent, may be immediately recovered.

(9) CHORE SERVICES. Chore services may be provided only in situations where no one else in the household is capable of either performing or paying for the services and no other relative, caregiver, landlord, community, volunteer agency, or third-party payer is capable of or responsible for providing these services

(10) TRANSPORTATION. Non-medical transportation is provided in order to enable a child to gain access to community services, activities, and resources as specified in the child's Plan of Care. Non-medical transportation excludes:

(a) Transportation provided by family members;

(b) Transportation used for behavioral intervention or calming;

(c) Transportation normally provided by schools and by the primary caregiver for children of similar age without disabilities;

(d) Purchase of any family vehicle;

(e) Vehicle maintenance and repair;

(f) Reimbursement for out-of-state travel expenses;

(g) Ambulance services; or

(h) Transportation services that may be obtained through other means such as the Oregon Health Plan or other public or private resources available to the child.

(11) FAMILY TRAINING. Family training services include the purchase of training, coaching, counseling, and support that increase the abilities of a child's family to care for and maintain the child in the family home. Family training services include:

(a) Counseling services that assist the family with the stresses of having a child with an intellectual or developmental disability.

(A) To be authorized, the counseling services must:

(i) Be provided by licensed providers including but not limited to psychologists licensed under ORS 675.030, professionals licensed to practice medicine under 677.100, social workers licensed under 675.530, or counselors licensed under 675.715;

(ii) Directly relate to the child's intellectual or developmental disability and the ability of the family to care for the child; and

(iii) Be short-term.

(B) Counseling services are excluded for:

(i) Therapy that could be obtained through the Oregon Health Plan or other payment mechanisms;

(ii) General marriage counseling;

(iii) Therapy to address the psychopathology of family members;

(iv) Counseling that addresses stressors not directly attributed to the child;

(v) Legal consultation;

(vi) Vocational training for family members; and

(vii) Training for families to carry out educational activities in lieu of school.

(b) Registration fees for organized conferences, workshops, and group trainings that offer information, education, training, and materials about the child's intellectual or developmental disability, medical, or health conditions.

(A) Conferences, workshops, or group trainings must be prior authorized by the services coordinator and include those that:

(i) Directly relate to the child's intellectual or developmental disability; and

(ii) Increase the knowledge and skills of the child's family to care for and maintain the child in the family home.

(B) Conference, workshop, or group training costs exclude:

(i) Registration fees in excess of $500 per family for an individual event;

(ii) Travel, food, and lodging expenses;

(iii) Services otherwise provided under the Oregon Health Plan or available through other resources; or

(iv) Costs for individual family members who are employed to care for the child.

(12) SPECIALIZED DIETS. Specialized diets do not constitute a full nutritional regime.

(a) In order for a specialized diet to be authorized:

(A) The foods must be on the approved list developed by the Department;

(B) The specialized diet must be ordered at least annually by a physician licensed by the Oregon Board of Medical Examiners;

(C) The specialized diet must be periodically monitored by a dietician or physician; and

(D) The specialized diet may not be reimbursed through the Oregon Health Plan or any other source of public and private funding.

(b) Restaurant and prepared foods, vitamins, and supplements are specifically excluded from a specialized diet.

(13) TRANSLATION. If the primary caregiver or the child's primary language is not English, translation service is provided to allow the child or the primary caregiver to communicate with providers of MFC services.

(14) The Department may expend its funds through contract, purchase order, use of credit card, payment directly to the vendor, or any other legal payment mechanism.

(15) MFC services for a child not on the Hospital Model Waiver are limited to IHDC services only.

(16) All MFC services authorized by the Department must be included in a written Plan of Care in order to be eligible for payment.

(17) The Plan of Care must use the most cost effective services for safely meeting the child's needs as determined by the services coordinator.

(18) SERVICE LEVELS. The Department must base the average monthly service budget for the MFC services authorized in the Plan of Care on the child's service level as follows:

(a) Level I.

(A) A child who is eligible for level I services must:

(i) Be ventilator-dependent for 20 or more hours per day;

(ii) Have a score on the clinical criteria of 75 or greater; and

(iii) Require that the provider or primary caregiver be awake for the full 24 hours.

(B) A child must be ventilator-dependent 24 hours per day for the maximum service budget to be allowed.

(b) Level II.

(A) A child who is eligible for level II services must:

(i) Be ventilator-dependent for 14 to 20 hours per day;

(ii) Have a score on the clinical criteria between 70 and 74; and

(iii) Require the provider or primary caregiver to remain awake for the full 24 hours.

(B) A child must be ventilator-dependent 20 hours per day for the maximum service budget to be allowed.

(c) Level III.

(A) A child who is eligible for level III services must:

(i) Be ventilator-dependent for 6 to 13 hours per day;

(ii) Have a score on the clinical criteria between 65 and 69; and

(iii) Require the provider or primary caregiver to remain awake for the full 24 hours.

(B) A child must be ventilator-dependent 13 hours per day for the maximum service budget to be allowed.

(d) Level IV.

(A) A child who is eligible for level IV services must:

(i) Be ventilator-dependent for up to six hours per day;

(ii) Have a score on the clinical criteria between 60 and 64; and

(iii) Require the provider or primary caregiver to remain awake for the full 24 hours.

(B) A child must be ventilator-dependent six hours per day for the maximum budget to be allowed.

(e) Level V. A child who is eligible for level V services must:

(A) Have a score on the clinical criteria between 50 and 59; and

(B) Require close proximity of the provider or primary caregiver to monitor for the full 24 hours.

(f) Level VI. A child who is eligible for level VI services must:

(A) Have a score on the clinical criteria less than 50;

(B) Meet the other eligibility criteria in OAR 411-350-0030; and

(C) Not have been transitioned out of MFC services.

(19) EXCEPTIONS. Exceptions, not to exceed 60 consecutive days without MFCU Supervisor review and approval, are only authorized by the Department in the following circumstances:

(a) To prevent the child's hospitalization.

(b) To provide initial teaching of new care needs.

(c) A significant medical condition or event occurs that prevents or seriously impedes the primary caregiver from providing services as documented by a physician.

(20) The Department only authorizes MFC services to enable the primary caregiver to meet the needs of caring for the child. All MFC services funded by the Department must be based on actual and customary costs related to best practice standards of care for children with similar disabilities.

(21) When multiple children in the same family home or setting qualify for MFC services, the same primary caregiver must provide services to all qualified children if services may be safely delivered by a single primary caregiver, as determined by the services coordinator.

(22) The Department shall not pay for MFC services that are:

(a) Notwithstanding abuse as defined in ORS 419B.005, abusive, aversive, or demeaning;

(b) Experimental;

(c) Illegal, including crimes identified in OAR 407-007-0275;

(d) Determined unsafe for the general public by recognized child and consumer safety agencies;

(e) Not necessary or cost effective;

(f) Educational services for school-age children, including professional instruction, formal training, and tutoring in communication, socialization, and academic skills;

(g) Services or activities that the legislative or executive branch of Oregon government has prohibited use of public funds;

(h) Medical treatments; or

(i) Services or supplies provided by private health insurance or OHP.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 427.005, 427.007 & 430.215

Hist.: MHD 21-1998(Temp), f. 11-25-98, cert. ef. 12-1-98 thru 5-29-99; MHD 3-1999, f. 5-17-99, cert. ef. 5-28-99; MHD 8-2003(Temp) f. & cert. ef. 12-11-03 thru 6-7-04; Renumbered from 309-044-0140, SPD 14-2004, f. & cert. ef. 6-1-04; SPD 1-2009, f. 2-24-09, cert. ef. 3-1-09; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 5-2010, f. 6-29-10, cert. ef. 7-1-10; SPD 28-2013(Temp), f. & cert. ef. 7-2-13 thru 12-29-13

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Rule Caption: Medically Involved Children's Program
Adm. Order No.: SPD 29-2013(Temp)
Filed with Sec. of State: 7-2-2013
Certified to be Effective: 7-2-13 thru 12-29-13
Notice Publication Date:
Rules Amended: 411-355-0010, 411-355-0020, 411-355-0030, 411-355-0040
Subject: The Department of Human Services (Department) is immediately amending the rules for the Medically Involved Children's Program in OAR chapter 411, division 355 to:

Reflect new definitions applicable to Community First Choice State Plan services;

Specify the eligibility requirements to reflect changes made as a result of the Community First Choice State Plan;

Describe and coincide with the services available in the Community First Choice State Plan and Home and Community-Based Waiver amendments;

Require a functional needs assessment as part of a child's service planning process; and

Clarify the responsibilities of a services coordinator when developing a child's Plan of Care.

Rules Coordinator: Christina Hartman—(503) 945-6398

411-355-0010
Definitions

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 355:

(1) "Abuse" means abuse of a child as defined in ORS 419B.005.

(2) "Activities of Daily Living (ADL)" mean those personal, functional activities required by a child for continued well-being that are essential for health and safety.

(3) "Behavior Consultant" means a contractor with specialized skills who meets the requirements of OAR 411-355-0050 and provides the services described in OAR 411-355-0040.

(4) "Behavior Support Plan (BSP)" means a written strategy based on person-centered planning and a functional assessment that outlines specific instructions for a provider to follow, to cause a child's challenging behaviors to become unnecessary, and to change the provider's own behavior, adjust environment, and teach new skills.

(5) "Billing Form" means the document generated by the Department that acts as a prior authorization, contract, and payment mechanism for services.

(6) "Billing Provider" means an organization that enrolls and contracts with the Department to provide services through an employee and bills the Department for the provider's services.

(7) "Child" means an individual who is under the age of 18 and applying for or eligible for the Medically Involved Children's Program.

(8) "Chore Services" mean the services described in OAR 411-355-0040 needed to maintain a clean, sanitary, and safe environment in a child's home. Chore services include heavy household chores such as washing floors, windows, and walls, tacking down loose rugs and tiles, and moving heavy items of furniture for safe access and egress. Chore services may

include yard hazard abatement to ensure the outside of the home is safe for the child to traverse and enter and exit the home.

(9) "CMS" means Centers for Medicare and Medicaid Services, the federal agency charged with delivery and oversight of all Medicare and Medicaid services.

(10) "Community First Choice State Plan" means Oregon's state plan amendment authorized under section 1915(k) of the Social Security Act.

(11) "Community Nursing Services" mean the services described in OAR 411-355-0040 that include nurse delegation and care coordination for a child living in his or her own home. Community nursing services do not include direct nursing care and are not covered by other Medicaid spending authorities

(12) "Cost Effective" means that in the opinion of the services coordinator, a specific service meets the child's service needs and costs less than, or is comparable to, other service options considered.

(13) "Delegation" means that a registered nurse authorizes an unlicensed person to perform nursing tasks and confirms that authorization in writing. Delegation may occur only after the registered nurse follows all steps of the delegation process as outlined in OAR chapter 851, division 047.

(14) "Department" means the Department of Human Services (DHS).

(15) "Developmental Disability (DD)" means a neurological condition that originates in the developmental years, that is likely to continue, and significantly impacts adaptive behavior as diagnosed and measured by a qualified professional as described in OAR 411-320-0080.

(16) "Director" means the Director of the Department's Office of Developmental Disability Services or the Director's designee. The term "Director" is synonymous with "Assistant Director".

(17) "Division" means "Department" as defined in this rule.

(18) "Environmental Accessibility Adaptations" mean the physical adaptations as described in OAR 411-355-0040 that are necessary to ensure the health, welfare, and safety of a child in the home, or that enable the child to function with greater independence in the home.

(19) "Family Home" means the residence of the child that is not a foster home, group home, or other residential service funded with public funds.

(20) "Family Training" means training and counseling services for the family of a child that increase the family's capacity to care for, support, and maintain the child in the home as described in OAR 411-355-0040.

(a) Family training includes:

(A) Instruction about treatment regimens and use of equipment specified in the child's Plan of Care;

(B) Information, education, and training about the child's intellectual or developmental disability, medical, or behavioral conditions; and

(C) Counseling for the family to relieve the stress associated with caring for a child with an intellectual or developmental disability.

(b) To determine who may receive family training, family means a unit of two or more persons that include at least one child with an intellectual or developmental disability where the primary caregiver is:

(A) Related to the child by blood, marriage, or legal adoption; or

(B) In a domestic relationship where partners share:

(i) A permanent residence;

(ii) Joint responsibility for the household in general (e.g. child-rearing, maintenance of the residence, basic living expenses); and

(iii) Joint responsibility for supporting the child and the child is related to one of the partners by blood, marriage, or legal adoption.

(21) "Founded Reports" means the Department's Children, Adults, and Families Division or Law Enforcement Authority (LEA) determination, based on the evidence, that there is reasonable cause to believe that conduct in violation of the child abuse statutes or rules has occurred and such conduct is attributable to the person alleged to have engaged in the conduct.

(22) "Functional Needs Assessment (FNAT)" means an assessment that documents the level of need, accommodates a child's participation in service planning, and includes --

(a) Completing a comprehensive and holistic assessment;

(b) Surveying physical, mental, and social functioning; and

(c) Identifying risk factors, choices and preferences, and service needs.

(23) "Home and Community-Based Waivered Services" mean the services approved by the Centers for Medicare and Medicaid Services in accordance with Section 1915(c) and 1115 of the Social Security Act.

(24) "Grievance" means a process by which a person may air complaints and seek remedies.

(25) "In-Home Daily Care (IHDC)" means Medicaid state plan funded essential supportive daily care as described in OAR 411-355-0040 delivered by a qualified provider that enables a child to remain, or return to, the family home.

(26) "Instrumental Activities of Daily Living (IADL)" mean those activities, other than activities of daily living, required to continue independent living.

(27) "Intellectual Disability" has the meaning set forth in OAR 411-320-0020 and described in OAR 411-320-0080.

(28) "Level of Care" means an assessment completed by a services coordinator has determined a child meets institutional level of care. A child meets institutional level of care for nursing facility level of care for children with intellectual or developmental disabilities if --

(a) A child has a documented medical condition that requires 24-hour professional nursing supervision and demonstrates the need for active treatment as assessed by the medically involved criteria as defined in this rule.

(b) A child's medical condition requires the care and treatment of services normally provided in a nursing facility.

(29) "Mandatory Reporter" means any public or private official as defined in OAR 407-045-0260 who comes in contact with and has reasonable cause to believe a child with or without an intellectual or developmental disability has suffered abuse, or comes in contact with any person whom the official has reasonable cause to believe abused a child, regardless of whether or not the knowledge of the abuse was gained in the reporter's official capacity. Nothing contained in ORS 40.225 to 40.295 affects the duty to report imposed by this section, except that a psychiatrist, psychologist, clergy, attorney, or guardian ad litem appointed under ORS 419B.231 is not required to report such information communicated by a person if the communication is privileged under ORS 40.225 to 40.295.

(30) "Medically Involved Children's Program (MICP)" means the waiver program granted by the federal Centers for Medicare and Medicaid Services that allows Title XIX funds to be spent on children living in their family home who otherwise would have to be served in a nursing facility if the waiver program was not available.

(31) "Medically Involved Criteria (Form DHS-0521)" means the assessment tool used by the Department to evaluate the intensity of the challenges presented by children eligible for the Medically Involved Children's Program.

(32) "MICP" means "Medically Involved Children's Program" as defined in this rule.

(33) "Natural Supports" or "Natural Support System" means the resources available from relatives, friends, significant others, neighbors, roommates, and the community. Services provided by natural supports are resources that are not paid for by the Department.

(34) "Nurse" means a person who holds a current license from the Oregon Board of Nursing as a registered nurse (RN) or licensed practical nurse (LPN) pursuant to ORS chapter 678.

(35) "Nursing Care Plan" means a plan of care developed by a nurse that describes the medical, nursing, psychosocial, and other needs of a child, and how those needs are met. The Nursing Care Plan includes the tasks that are taught or delegated to the qualified provider or parent. When a Nursing Care Plan exists, it becomes a part of the Plan of Care.

(36) "Nursing Facility (NF)" means a residential medical facility.

(37) "Nursing Tasks or Services" means the care or services that require the education and training of a licensed professional nurse to perform. Nursing tasks or services may be delegated.

(38) "OHP" means the Oregon Health Plan.

(39) "Oregon Intervention System (OIS)" means a system of providing training to people who work with designated individuals to intervene physically or non-physically to keep individuals from harming self or others. OIS is based on a positive approach that includes methods of effective evasion, deflection, and escape from holding.

(40) "OSIP-M" means Oregon Supplemental Income Program-Medical as defined in OAR 461-101-0010. OSIP-M is Oregon Medicaid insurance coverage for those who meet the eligibility criteria as described in OAR chapter 461.

(41) "Parent" means biological parent, adoptive parent, stepparent, or legal guardian.

(42) "Person-Centered Planning" means:

(a) A process, either formal or informal, for gathering and organizing information that helps:

(A) Determine and describe choices about personal goals, activities, and lifestyle preferences;

(B) Design strategies and networks of support to achieve goals and a preferred lifestyle using strengths, relationships, and resources; and

(C) Identify, use, and strengthen naturally occurring opportunities for support at home and in the community.

(b) The methods for gathering information vary, but all are consistent with a child's needs and preferences.

(43) "Personal Care Services" means assistance with activities of daily living, instrumental activities of daily living, and health-related tasks through cueing, monitoring, reassurance, redirection, set-up, hands-on, standby assistance, and reminding.

(44) "Plan of Care (POC)" means the written details of the supports, activities, and resources required for a child to achieve personal outcomes. Individual support needs are identified through a functional needs assessment. The manner in which services are delivered, service providers, and the frequency of services are reflected in a Plan of Care. The Plan of Care is developed at minimum annually to reflect decisions and agreements made during a person-centered process of planning and information gathering. The Plan of Care includes a Nursing Care Plan when one exists. The Plan of Care reflects whether services are provided through a waiver, state plan, or through a child's natural supports.

(45) "Positive Behavioral Theory and Practice" means a proactive approach to behavior and behavior interventions that:

(a) Emphasizes the development of functional alternative behavior and positive behavior intervention;

(b) Uses the least intervention possible;

(c) Ensures that abuse or demeaning interventions are never used; and

(d) Evaluates the effectiveness of behavior interventions based on objective data.

(46) "Primary Caregiver" means the parent, relative, or other non-paid parental figure that provides the direct care of the child at the times that a paid provider is not available.

(47) "Provider or Performing Provider" means an individual who meets the requirements of OAR 411-355-0050 that is qualified to receive payment from the Department for in-home daily care. Providers work directly with children. Providers may be employees of billing providers, employees of a child's parent, or independent contractors.

(48) "Respite" means intermittent services as described in OAR 411-355-0040 provided on a periodic basis, but not more than 14 consecutive days, for the relief of, or due to the temporary absence of a child's primary caregiver.

(49) "Service Level" means the monthly dollar amount allotted for the care of the child based on a medically involved criteria. The service level consists of in-home daily care and, if the child is on a waiver, waivered services.

(50) "Services Coordinator" means an employee of the Department who ensures a child's eligibility for the Medically Involved Children's Program and provides assessment, case management, service implementation, and evaluation of the effectiveness of the services.

(51) "Specialized Diet" means specially prepared or particular types of food needed to sustain a child in the family home as described in OAR 411-355-0040.

(52) "Specialized Equipment and Supplies" mean devices, aids, controls, supplies, or appliances as described in OAR 411-355-0040 that meet applicable standards of manufacture, design, and installation that enable children to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. Specialized equipment and supplies do not include items not of direct benefit to a child.

(53) "Substantiated" means an abuse investigation has been completed by the Department or the Department's designee and the preponderance of the evidence establishes the abuse occurred.

(54) "Supplant" means take the place of.

(55) "These Rules" mean the rules in OAR chapter 411, division 355.

(56) "Transportation" means services as described in OAR 411-355-0040 that allow a child to gain access to community services, activities, and resources that are not medical in nature.

(57) "Volunteer" means any person providing services without pay to individuals receiving Medically Involved Children's Program services.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 427.007 & 430.215
Hist.: SPD 5-2008(Temp), f. & cert. ef. 4-15-08 thru 10-12-08; SPD 14-2008, f. & cert. ef 10-9-08; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 5-2010, f. 6-29-10, cert. ef. 7-1-10; SPD 29-2013(Temp), f. & cert. ef. 7-2-13 thru 12-29-13

411-355-0020
Eligibility

(1) ELIGIBILITY. In order to be eligible for the MICP, the child must:

(a) Be under the age of 18;

(b) Be a U.S. citizen;

(c) Be eligible for OSIP-M;

(d) Be eligible to receive Title XIX (Medicaid) services; (b) Require nursing facility level of care;

(e) Be accepted by the Department by scoring 100 or greater on the medically involved criteria within four months of starting services;

(f) After completion of an assessment, meet the level of care defined in OAR 411-355-0010;

(g) Require services offered under the MICP;

(h) Reside in the family home or reside in a nursing facility and wish to return to the family home; and

(i) Be capable of being safely served in the family home. This includes, but is not limited to, the parent demonstrating the willingness, skills, and ability to provide the direct care as outlined in the plan of care in a cost effective manner as determined by the service coordinator within the limitations of OAR 411-355-0040.

(2) INELIGIBILITY. A child is not eligible for the MICP if the child:

(a) Continues to reside in a hospital, school, sub-acute facility, nursing facility, intermediate care facility, residential facility, foster home, or other institution;

(b) Does not require waivered services, Community First Choice State Plan services, or has sufficient family, government, or community resources available to provide for his or her care; or

(c) Is not safely served in the family home as described in section (1)(i) of this rule.

(3) DISENROLLMENT. A child is disenrolled from the MICP when:

(a) The child no longer meets the medically involved criteria of section (1) of this rule; or

(b) The child's medically involved criteria score falls below 80.

(4) REDETERMINATION. The Department redetermines a child's eligibility for the MICP using the medically involved criteria at a minimum of every 12 months, or as the child's status changes.

(5) ENROLLMENT. If a child meets the criteria of section (1) of this rule and space is available in the MICP, the child's priority for enrollment is in accordance with ORS 417.345, CMS model waiver requirements, and geographical distribution for equal access to services. The date the initial application is complete is the date that the Department receives all of the required demographic and referral information on the child.

(6) WAIT LIST. The Department may place a child eligible for the MICP on a wait list if the allowable numbers of children in the MICP are already being served.

(a) The date the initial application for the MICP is completed determines the order on the wait list. A child previously enrolled in children's intensive in-home services that currently meets eligibility criteria and applies for the MICP is put on the wait list as of the date the child's original application for services was complete.

(b) Children on the wait list are served on a first come, first served basis according to the legislatively mandated enrollment priorities, per geographical region, and as space on the MICP allows.

(7) ASSESSMENT. Anyone may request an assessment for a child for MICP services.

Stat. Auth.: ORS 409.050 & 417.345
Stats. Implemented: ORS 417.345, 427.007 & 430.215
Hist.: SPD 5-2008(Temp), f. & cert. ef. 4-15-08 thru 10-12-08; SPD 14-2008, f. & cert. ef 10-9-08; SPD 29-2013(Temp), f. & cert. ef. 7-2-13 thru 12-29-13

411-355-0030
Plan of Care

(1) To develop the Plan of Care, the service coordinator must complete an FNAT using a person-centered planning approach and assess the service needs of the child. The assessment must take place in person and the services coordinator must interview the child's parent, provider, or other interested individuals as appropriate. The assessment must identify:

(a) The current care needs of the child including ADL care, medication management, communication, supervisory needs, and physical environment;

(b) The services for which the child is currently eligible;

(c) The services currently being provided;

(d) All available family, private health insurance, and government or community resources that meet any, some, or all of the child's needs; and

(e) Areas of unmet needs.

(2) The service coordinator must prepare, with the input of the parent and any other individual at the parent's request, a written plan of care that identifies:

(a) The service needs of the child and the child's family;

(b) The most cost effective services for safely and appropriately meeting the child's service needs; and

(c) The methods, resources, and strategies that address some or all of the child's service needs.

(3) The service coordinator must prepare a Plan of Care that includes:

(a) A description of the supports required, including the reason the support is necessary. For an initial or annual Plan of Care that is authorized on or after July 1, 2013, the description must be consistent with the FNAT;

(b) A list of personal, community, and public resources that are available to the child and how the resources may be applied to provide the required supports. Sources of support may include waivered or state plan services, state general funds, or natural supports

(c) The maximum hours of authorized provider services;

(d) The annual average service level;

(e) The number of hours of in-home daily care or other related services authorized for the child;

(f) Additional services authorized by the Department for the child:

(g) The date of the next Plan of Care review that, at a minimum, must be completed within 12 months of the last Plan of Care;

(h) The child's Nursing Care Plan, when one exists; and

(i) All behavior and specialized consultant services purchased through the MICP.

(4) The parent must review the Plan of Care prior to implementation.

(5) The parent and the services coordinator must sign the Plan of Care and a copy must be provided to the parent.

(6) The services coordinator must reflect significant changes in the needs of the child in the Plan of Care, as they occur, and provide a copy of the updated Plan of Care to the parent.

Stat. Auth.: ORS 409.050 & 417.345

Stats. Implemented: ORS 417.345, 427.007 & 430.215

Hist.: SPD 5-2008(Temp), f. & cert. ef. 4-15-08 thru 10-12-08; SPD 14-2008, f. & cert. ef 10-9-08; SPD 29-2013(Temp), f. & cert. ef. 7-2-13 thru 12-29-13

411-355-0040

Scope and Limitations of MICP Services

(1) To be authorized and eligible for payment by the Department, all MICP supports and services must be:

(a) Directly related to the child's disability;

(b) Required to maintain the health and safety of the child;

(c) Cost effective;

(d) Considered not typical for a parent to provide a child of the same age;

(e) Required to help the parent to continue to meet the needs of caring for the child; and

(f) Included in an approved Plan of Care.

(2) The annual average service level, as authorized by the Department in the Plan of Care, dated from the initial Plan of Care to the anniversary date, may not exceed the allowed maximum service level amount. Service levels increase or decrease in direct relationship to the increasing or decreasing medically involved criteria score.

(3) The Department authorizes 90 day exceptions in the following circumstances:

(a) The child is at immediate risk of loss of the family home without the expenditure;

(b) The expenditure provides supports for emerging or changing care needs; or

(c) A significant medical condition or event occurs that prevents the primary caregiver from providing care or services as documented by a physician.

(4) The Department evaluates exceptions beyond 90 days on an individual basis using the criteria in section (3) of this rule

(5) The Department shall not pay for MICP services that are:

(a) Notwithstanding abuse as defined in ORS 419B.005, abusive, aversive, or demeaning;

(b) Experimental;

(c) Illegal, including crimes identified in OAR 407-007-0275;

(d) Determined unsafe for the general public by recognized child and consumer safety agencies;

(e) Not necessary or cost effective;

(f) Educational services for school-age children, including professional instruction, formal training, and tutoring in communication, socialization, and academic skills; or

(g) Services or activities that the legislative or executive branch of Oregon government has prohibited use of public funds.

(6) When multiple children in the same family home or setting qualify for MICP services, the same provider must provide services to all qualified children if services may be safely delivered by a single provider, as determined by the services coordinator.

(7) For an initial or annual Plan of Care that is authorized on or after July 1, 2013, MICP services may include a combination of the following waivered and other Medicaid services based upon the needs of a child as determined by the services coordinator and as consistent with the child's Plan of Care:

(a) Community First Choice State Plan services:

(A) Specialized consultation including behavior consultation as described in section (8) of this rule;

(B) Community nursing services as described in section (9) of this rule;

(C) Environmental accessibility adaptations as described in section (10) of this rule;

(D) In-home daily care as described in section (11) of this rule;

(E) Respite as described in section (12) of this rule;

(F) Specialized equipment and supplies as described in section (13) of this rule;

(G) Chore services as described in section (14) of this rule; and

(H) Transportation as described in section (15) of this rule.

(b) Waivered services:

(A) Family training as described in section (16) of this rule;

(B) Specialized diets as described in section (17) of this rule; and

(C) Translation as described in section (18) of this rule.

(8) SPECIALIZED CONSULTATION – BEHAVIOR CONSULTATION. Behavior consultation is only authorized to support a primary caregiver in their caregiving role. Behavior consultation is only authorized, as needed, to respond to specific problems identified by a primary caregiver or services coordinator. Behavior consultants must:

(a) Work with the primary caregiver to identify:

(A) Areas of a child's family home life that are of most concern for the parent and child;

(B) The formal or informal responses the family or provider has used in those areas; and

(C) The unique characteristics of the family that may influence the responses that may work with the child.

(b) Assess the child. The assessment must include:

(A) Specific identification of the behaviors or areas of concern;

(B) Identification of the settings or events likely to be associated with, or to trigger, the behavior;

(C) Identification of early warning signs of the behavior;

(D) Identification of the probable reasons that are causing the behavior and the needs of the child that are being met by the behavior, including the possibility that the behavior is:

(i) An effort to communicate;

(ii) The result of a medical condition;

(iii) The result of an environmental cause; or

(iv) The symptom of an emotional or psychiatric disorder.

(E) Evaluation and identification of the impact of disabilities (i.e. autism, blindness, deafness, etc.) that impact the development of strategies and affect the child and the area of concern; and

(F) An assessment of current communication strategies.

(c) Develop a variety of positive strategies that assist the primary caregiver and provider to help the child use acceptable, alternative actions to meet the child's needs in the most cost effective manner. These strategies may include changes in the physical and social environment, developing effective communication, and appropriate responses by a primary caregiver and provider to the early warning signs.

(A) Positive, preventive interventions must be emphasized.

(B) The least intrusive intervention possible must be used.

(C) Abusive or demeaning interventions must never be used.

(D) The strategies must be adapted to the specific disabilities of the child and the style or culture of the family.

(d) Develop emergency and crisis procedures to be used to keep the child, primary caregiver, and provider safe. When interventions in the behavior of the child are necessary, positive, preventative, non-aversive interventions that conform to OIS must be utilized.

(e) Develop a written Behavior Support Plan that includes the following:

(A) Use of clear, concrete language that is understandable to the primary caregiver and provider; and

(B) Describes the assessment, strategies, and procedures to be used.

(f) Teach the provider and primary caregiver the strategies and procedures to be used.

(g) Monitor and revise the Behavior Support Plan as needed.

(9) COMMUNITY NURSING SERVICES.

(a) Evaluation and identification of supports that minimize health risks, while promoting the child's autonomy and self-management of healthcare;

(b) Medication reviews;

(c) Collateral contact with the services coordinator regarding the child's community health status to assist in monitoring safety and well-being and to address needed changes to the person-centered Plan of Care; and

(d) Delegation of nursing tasks to a provider and primary caregiver so that caregivers may safely perform health related tasks.

(10) ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS. Environmental accessibility adaptations are physical adaptations to a family home that are necessary to ensure the health, welfare, and safety of the child in the family home due to the child's intellectual or developmental disability or that are necessary to enable the child to function with greater independence around the family home and in family activities.

(a) Environmental accessibility adaptations include but are not limited to:

(A) An environmental modification consultation to determine the appropriate type of adaptation to ensure the health, welfare, and safety of the child;

(B) Installation of shatter-proof windows;

(C) Hardening of walls or doors;

(D) Specialized, hardened, waterproof, or padded flooring;

(E) An alarm system for doors or windows;

(F) Protective covering for smoke detectors, light fixtures, and appliances;

(G) Sound and visual monitoring systems;

(H) Fencing;

(I) Installation of ramps, grab-bars, and electric door openers;

(J) Adaptation of kitchen cabinets and sinks;

(K) Widening of doorways;

(L) Handrails;

(M) Modification of bathroom facilities;

(N) Individual room air conditioners for a child whose temperature sensitivity issues create behaviors or medical conditions that put the child or others at risk;

(O) Installation of non-skid surfaces;

(P) Overhead track systems to assist with lifting or transferring;

(Q) Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the child;

(R) Modifications for the primary vehicle used by the child that are necessary to meet the unique needs of the child and ensure the health, welfare, and safety of the child (lift or interior alterations such as seats, head, and leg rests; and belts, special safety harnesses, or other unique modifications to keep the child safe in the vehicle); and

(S) Adaptations to control lights, heat, stove, etc.

(b) Environmental accessibility adaptations exclude:

(A) Adaptations or improvements to the family home that are of general utility and are not for the direct safety, remedial, or long term benefit to the child;

(B) Adaptations that add to the total square footage of the family home; and

(C) General repair or maintenance and upkeep required for the family home or motor vehicle, including repair of damage caused by the child.

(c) Environmental modifications are limited to $5,000 per modification. A services coordinator may request approval for additional expenditures through the Department prior to expenditure. Approval is based on the child's service needs and goals and the Department's determination of appropriateness and cost-effectiveness.

(d) Environmental modifications must be tied to supporting activities of daily living, instrumental activities of daily living, and health-related tasks as identified in the Plan of Care.

(e) Modifications over $500 must be completed by a state licensed contractor. Any modification requiring a permit must be inspected and be certified as in compliance with local codes by local inspectors and filed in provider file prior to payment. Environmental modifications must be made within the existing square footage of the family home, except for external ramps, and cannot add to the square footage of the building. Payment to the contractor is to be withheld until the work meets specifications.

(f) Environmental accessibility adaptations that are provided in a rental structure must be authorized in writing by the owner of the structure prior to initiation of the work. This does not preclude any reasonable accommodations required under the Americans with Disabilities Act.

(11) IN-HOME DAILY CARE. In-home daily care services include the purchase of direct provider support provided to a child in the family home or community by qualified individual providers and agencies. Provider assistance provided through in-home daily care must support the child to live as independently as appropriate for the child's age and must be based on the identified needs of the child, supporting the family in a primary caregiving role. Primary caregivers are expected to be present or immediately available during the provision of in-home daily care.

(a) In-home daily care services provided by qualified providers or agencies include:

(A) Basic personal hygiene - Assistance with bathing and grooming;

(B) Toileting, bowel, and bladder care - Assistance in the bathroom, diapering, external cleansing of perineal area, and care of catheters;

(C) Mobility — Transfers, comfort, positioning, and assistance with range of motion exercises;

(D) Nutrition — feeding and monitoring intake and output;

(E) Skin care — Dressing changes;

(F) Physical healthcare including delegated nursing tasks;

(G) Supervision — Providing an environment that is safe and meaningful for the child and interacting with the child to prevent danger to the child and others, and maintain skills and behaviors required to live in the home and community;

(H) Assisting the child with appropriate leisure activities to enhance development in the family home and community and provide training and support in personal environmental skills;

(I) Communication — Assisting the child in communicating, using any means used by the child;

(J) Neurological — Monitoring of seizures, administering medication, and observing status; and

(K) Accompanying the child and family to health related appointments.

(b) In-home daily care services must:

(A) Be previously authorized by the services coordinator before services begin;

(B) Be delivered through the most cost effective method as determined by the services coordinator; and

(C) Only be provided when the child is present to receive services.

(c) In-home daily care services exclude:

(A) Hours that supplant the natural supports and services available from family, community, other government or public services, insurance plans, schools, philanthropic organizations, friends, or relatives;

(B) Hours to allow a primary caregiver to work or attend school;

(C) Support generally provided at the child's age by parents or other family members;

(D) Educational and supportive services provided by schools as part of a free and appropriate education for children and young adults under the Individuals with Disabilities Education Act;

(E) Services provided by the family; and

(F) Home schooling.

(d) In-home daily care services may not be provided on a 24-hour shift-staffing basis. The child's primary caregiver is expected to provide at least 40 hours of care each week and supervise the child each day with the exception of overnight respite. The 40 hours of care and supervision may not include hours when the child's primary caregiver is sleeping.

(12) RESPITE. Respite services are provided to a child on a periodic or intermittent basis furnished because of the temporary absence of, or need for relief of, the primary caregiver.

(a) Respite may include both day and overnight services that may be provided in:

(A) The family home;

(B) A licensed, certified, or otherwise regulated setting;

(C) A qualified provider's home. If overnight respite is provided in a qualified provider's home, the services coordinator and the child's parent must document that the home is a safe setting for the child; or

(D) A disability-related or therapeutic recreational camp.

(b) The services coordinator does not authorize respite services:

(A) To allow primary caregivers to attend school or work;

(B) That are ongoing and occur on more than a periodic schedule, such as eight hours a day, five days a week;

(C) On more than 14 consecutive overnight stays in a calendar month;

(D) For more than 10 days per individual plan year when provided at a specialized camp;

(E) For vacation travel and lodging expenses; or

(F) To pay for room and board if provided at a licensed site or specialized camp.

(13) SPECIALIZED EQUIPMENT AND SUPPLIES. Specialized equipment and supplies include the purchase of devices, aids, controls, supplies, or appliances that are necessary to enable a child to increase the child's abilities to perform and support activities of daily living, or to perceive, control, or communicate with the environment in which the child lives.

(a) Electronic devices to secure assistance in an emergency in the community and other reminders such as medication minders and alert systems for ADL/IADL supports, or mobile electronic devices. Expenditures for electronic devices of more than $500 in a plan year require Department approval.

(b) Assistive technology to provide additional security and replace the need for direct interventions to allow self direction of care and maximize independence. Examples include motion sound sensors, two-way communication systems, automatic faucets and soap dispensers, incontinent and fall sensors, or other electronic backup systems.

(A) Limit of $5000 per year without Department approval.

(B) Any single device or assistance costing more than $500 must be approved by the Department.

(c) Assistive devices. Examples include durable medical equipment, mechanical apparatus, electrical appliance or information technology device to assist and enhance an individual's independence in performing ADL/IADLs, not covered by other Medicaid programs. Limit of $5000 per year without Department approval. Any single device or assistance costing more than $500 must be approved by the department.

(d) The purchase of specialized equipment and supplies may include the cost of a professional consultation, if required, to assess, identify, adapt, or fit specialized equipment. The cost of professional consultation may be included in the purchase price of the equipment.

(e) To be authorized by the services coordinator, specialized equipment and supplies must be:

(A) In addition to any medical equipment and supplies furnished under the Oregon Health Plan and private insurance;

(B) Determined necessary to the daily functions of the child; and

(C) Directly related to a child's disability.

(f) Specialized equipment and supplies exclude:

(A) Items that are not necessary or of direct medical or remedial benefit to the child;

(B) Specialized equipment and supplies intended to supplant similar items furnished under the Oregon Health Plan or private insurance;

(C) Items available through family, community, or other governmental resources;

(D) Items that are considered unsafe for a child;

(E) Toys or outdoor play equipment; and

(F) Equipment and furnishings of general household use.

(g) Funding for specialized equipment with an expected life of more than one year is one time funding that is not continued in subsequent plan years. Specialized equipment may only be included in a child's annual Plan of Care when all other public and private resources for the equipment have been exhausted.

(h) The services coordinator must secure use of equipment or furnishings costing more than $500 through a written agreement between the Department and the child's parent that specifies the time period the item is to be available to the child and the responsibilities of all parties if the item is lost, damaged, or sold within that time period. Any equipment or supplies purchased with MICP funds that are not used according to the child's annual Plan of Care, or according to the written agreement between the Department and the child's parent, may be immediately recovered.

(14) CHORE SERVICES. Chore services may be provided only in situations where no one else in the household is capable of either performing or paying for the services and no other relative, caregiver, landlord, community, volunteer agency, or third-party payer is capable of or responsible for providing these services

(15) TRANSPORTATION. Non-medical transportation is provided in order to enable a child to gain access to community services, activities, and resources as specified in the child's Plan of Care. Non-medical transportation excludes:

(a) Transportation provided by family members;

(b) Transportation used for behavioral intervention or calming;

(c) Transportation normally provided by schools and by the primary caregiver for children of similar age without disabilities;

(d) Purchase of any family vehicle;

(e) Vehicle maintenance and repair;

(f) Reimbursement for out-of-state travel expenses;

(g) Ambulance services; or

(h) Transportation services that may be obtained through other means such as the Oregon Health Plan or other public or private resources available to the child.

(16) FAMILY TRAINING. Family training services include the purchase of training, coaching, counseling, and support that increase the abilities of a child's family to care for and maintain the child in the family home. Family training services include:

(a) Counseling services that assist the family with the stresses of having a child with an intellectual or developmental disability.

(A) To be authorized, the counseling services must:

(i) Be provided by licensed providers including but not limited to psychologists licensed under ORS 675.030, professionals licensed to practice medicine under ORS 677.100, social workers licensed under ORS 675.530, or counselors licensed under ORS 675.715;

(ii) Directly relate to the child's intellectual or developmental disability and the ability of the family to care for the child; and

(iii) Be short-term.

(B) Counseling services are excluded for:

(i) Therapy that could be obtained through the Oregon Health Plan or other payment mechanisms;

(ii) General marriage counseling;

(iii) Therapy to address the psychopathology of family members;

(iv) Counseling that addresses stressors not directly attributed to the child;

(v) Legal consultation;

(vi) Vocational training for family members; and

(vii) Training for families to carry out educational activities in lieu of school.

(b) Registration fees for organized conferences, workshops, and group trainings that offer information, education, training, and materials about the child's intellectual or developmental disability, medical, or health conditions.

(A) Conferences, workshops, or group trainings must be prior authorized by the services coordinator and include those that:

(i) Directly relate to the child's intellectual or developmental disability; and

(ii) Increase the knowledge and skills of the child's family to care for and maintain the child in the family home.

(B) Conference, workshop, or group training costs exclude:

(i) Registration fees in excess of $500 per family for an individual event;

(ii) Travel, food, and lodging expenses;

(iii) Services otherwise provided under the Oregon Health Plan or available through other resources; or

(iv) Costs for individual family members who are employed to care for the child.

(17) SPECIALIZED DIETS. Specialized diets do not constitute a full nutritional regime.

(a) In order for a specialized diet to be authorized:

(A) The foods must be on the approved list developed by the Department;

(B) The specialized diet must be ordered at least annually by a physician licensed by the Oregon Board of Medical Examiners;

(C) The specialized diet must be periodically monitored by a dietician or physician; and

(D) The specialized diet may not be reimbursed through the Oregon Health Plan or any other source of public and private funding.

(b) Restaurant and prepared foods, vitamins, and supplements are specifically excluded from a specialized diet.

(18) TRANSLATION. If the primary caregiver or the child's primary language is not English, translation service is provided to allow the child or the primary caregiver to communicate with providers of MICP services.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 427.007 & 430.215
Hist.: SPD 5-2008(Temp), f. & cert. ef. 4-15-08 thru 10-12-08; SPD 14-2008, f. & cert. ef 10-9-08; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 5-2010, f. 6-29-10, cert. ef. 7-1-10; SPD 29-2013(Temp), f. & cert. ef. 7-2-13 thru 12-29-13

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Rule Caption: Support Services for Adults with Intellectual or Developmental Disabilities — Definitions
Adm. Order No.: SPD 30-2013(Temp)
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Rules Amended: 411-340-0020
Rules Suspended: 411-340-0020(T)
Subject: The Department of Human Services (Department) is immediately amending the support services rules for adults with intellectual or developmental disabilities in OAR chapter 411, division 340 to reflect new definitions applicable to Community First Choice State Plan services.
Rules Coordinator: Christina Hartman—(503) 945-6398

411-340-0020
Definitions

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 340:

(1) "Abuse" means abuse of an adult as defined in OAR 407-045-0260.

(2) "Abuse Investigation and Protective Services" means reporting and investigation activities as required by OAR 407-045-0300 and any subsequent services or supports necessary to prevent further abuse as required by 407-045-0310.

(3) "Activities of Daily Living (ADL)" mean those personal, functional activities required by an individual for continued well-being that are essential for health and safety.

(4) "Adaptive Behavior" means the degree to which an individual meets the standards of personal independence and social responsibility expected for age and culture group.

(5) "Administration of Medication" means the act of placing a medication in, or on, an individual's body by a person responsible for the individual's care and employed by or under contract to the individual, the individual's legal representative, or a provider organization.

(6) "Administrative Review" means the formal process that is used when the individual or the individual's legal representative is not satisfied with the decision made by the brokerage about a complaint involving the provision of services or a provider.

(7) "Administrator" means the Administrator of the Department, or that person's designee. The term "Administrator" is synonymous with "Assistant Director".

(8) "Adult" means an individual 18 years or older with intellectual developmental disabilities.

(9) "Alternative Resources" mean possible resources, not including support services, for the provision of supports to meet an individual's needs. Alternative resources includes but is not limited to private or public insurance, vocational rehabilitation services, supports available through the Oregon Department of Education, or other community supports.

(10) "Alternatives to Employment - Habilitation" means assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that takes place in a non-residential setting, separate from the home in which an individual with an intellectual or developmental disability resides.

(11) "Annual Plan" means a written summary the personal agent completes for an individual 18 years or older who is not receiving support services

(12) "Basic Benefit" means the type and amount of support services available to each eligible individual, specifically:

(a) Access to the brokerage services listed in OAR 411-340-0120(1); and if required

(b) For individuals whose entry into support services occurred prior to October 1, 2013, access to an amount of support services funds used to assist with the purchase of supports listed in OAR 411-340-0130(6).

(13) "Basic Supplement" means an amount of support services funds in excess of the basic benefit to which an individual whose entry into support services occurred prior to October 1, 2013 may have access in order to purchase necessary supports based on demonstration of extraordinary long-term need on the Basic Supplement Criteria Inventory, Form DHS 0203.

(14) "Basic Supplement Criteria Inventory (Form DHS 0203)" means the written inventory of an individual's circumstances that is completed and scored by the brokerage to determine whether the individual whose entry into support services occurred prior to October 1, 2103 is eligible for a basic supplement.

(15) "Behavior Support Plan (BSP)" means a written strategy based on person-centered planning and a functional assessment that outlines specific instructions for a provider to follow, to cause a child's challenging behaviors to become unnecessary, and to change the provider's own behavior, adjust environment, and teach new skills.

(16) "Behavior Support Services" mean services that are provided to assist with behavioral challenges due to an individual's intellectual or developmental disability that prevents the individual from accomplishing activities of daily living, instrumental activities of daily living, and health related tasks.

(17) "Benefit Level" means the total annual amount of support service funds for which an individual whose entry into support services occurred prior to October 1, 2013, is eligible. The benefit level includes the basic benefit and any exceptions to the basic benefit financial limits.

(18) "Case Management" means an organized service to assist individuals to select, obtain, and utilize resources and services.

(19) "Certificate" means a document issued by the Department to a brokerage, or to a provider organization requiring certification under OAR 411-340-0170(2), that certifies the brokerage or provider organization is eligible to receive state funds for support services.

(20) "Choice" means an individual's expression of preference, opportunity for, and active role in decision-making related to services received and from whom, including but not limited to case management, service providers, and service settings. Personal outcomes, goals, and activities are supported in the context of balancing an individual's rights, risks, and personal choices. Individuals are supported in opportunities to make changes when so expressed. Choice may be communicated verbally, through sign language, or by other communication methods.

(21) "Chore Services" mean the services described in OAR 411-340-0130 needed to maintain a clean, sanitary, and safe environment in an individual's home. Chore services include heavy household chores such as washing floors, windows, and walls, tacking down loose rugs and tiles, and moving heavy items of furniture for safe access and egress. Chore services may include yard hazard abatement to ensure the outside of the home is safe for the individual to traverse and enter and exit the home.

(22) "Client Process Monitoring System (CPMS)" means the Department's computerized system for enrolling and terminating services for individuals with intellectual or developmental disabilities.

(23) "Community Developmental Disability Program (CDDP)" means an entity that is responsible for planning and delivery of services for individuals with intellectual or developmental disabilities according to OAR chapter 411, division 320. A CDDP operates in a specific geographic service area of the state under a contract with the Department, Local Mental Health Authority, or other entity as contracted by the Department.

(24) "Community First Choice State Plan" means Oregon's state plan amendment authorized under section 1915(k) of the Social Security Act.

(25) "Community Living and Inclusion Supports" mean services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and non-activities of daily living or instrumental activities of daily living skills necessary to reside successfully in home and community-based settings. Community living and inclusion supports assist individuals in acquiring, retaining, and improving skills around socialization, recreation and leisure, communication, participation in the community, and ability to direct supports.

(a) Support with socialization includes assisting participants in acquiring, retaining and improving self-awareness and self control, social responsiveness, social amenities, and interpersonal skills.

(b) Support with community participation, recreation, or leisure includes assisting individuals in acquiring, retaining, and improving skills to use available community services, facilities, or businesses.

(c) Support with communication includes assisting individuals in acquiring, retaining, and improving expressive and receptive skills in verbal and non-verbal language and the functional application of acquired reading and writing skills.

(d) Supports may be work-related and include instruction in skills an individual wishes to acquire, retain, or improve that enhance independence, productivity, integration, or maintain the individual's physical and cognitive skills.

(26) "Community Nursing Services" mean the services described in OAR 411-340-0130 that include nurse delegation and care coordination for an individual living in his or her own home. Community nursing services do not include direct nursing care and are not covered by other Medicaid spending authorities

(27) "Complaint" means a verbal or written expression of dissatisfaction with services or providers.

(28) "Comprehensive Services" mean developmental disability services and supports that include 24-hour residential services provided in a group home, foster home, or through a supported living program. Comprehensive services are regulated by the Department alone or in combination with an associated Department-regulated employment or community inclusion program. Comprehensive services are in-home services provided to an individual with an intellectual or developmental disability when

the individual receives case management services from a community developmental disability program. Comprehensive services do not include support services for adults with intellectual or developmental disabilities enrolled in brokerages.

(29) "Cost Effective" means being responsible and accountable with Department resources by offering less costly alternatives when providing choices that adequately meet an individual's support needs. Less costly alternatives include other programs available from the Department, the utilization of assistive devices, natural supports, architectural modifications, and alternative resources. Less costly alternatives may include resources not paid for by the Department.

(30) "Crisis" means:

(a) A situation that may result in civil court commitment under ORS 427.215 to 427.306 and for which no appropriate alternative resources are available; or

(b) Risk factors described in OAR 411-320-0160 are present for which no appropriate alternative resources are available.

(31) "Crisis Diversion Services" mean the services authorized and provided according to OAR 411-320-0160 that are intended to maintain an individual at home or in the family home while an individual is in emergent status. Crisis diversion services may include short-term residential placement services indicated on an individual's Support Services Brokerage Plan of Care Crisis Addendum, as well as additional support as described in an Individual Support Plan.

(32) "Department" means the Department of Human Services (DHS). The term "Department" is synonymous with "Division (SPD)".

(33) "Developmental Disability" means a neurological condition that originates in the developmental years, that is likely to continue, and significantly impacts adaptive behavior as diagnosed and measured by a qualified professional as described in OAR 411-320-0080.

(34) "Emergent Status" means an individual has been determined to be eligible for crisis diversion services according to OAR 411-320-0160.

(35) "Employer-Related Supports" mean activities that assist individuals and, when applicable, their family members with fulfilling roles and obligations as employers as described in the Individual Support Plan. Supports to the employer include but are not limited to:

(a) Education about employer responsibilities;

(b) Orientation to basic wage and hour issues;

(c) Use of common employer-related tools such as job descriptions; and

(d) Fiscal intermediary services.

(36) "Entry" means admission to a Department-funded developmental disability service provider.

(37) "Environmental Accessibility Adaptations" mean physical adaptations as described in OAR 411-340-0130 that are necessary to ensure the health, welfare, and safety of the individual in the home, or that enable the individual to function with greater independence in the home.

(38) "Environmental Modification Consultant" means either an independent provider, provider organization, or general business paid with support services funds, to provide advice to an individual, the individual's legal representative, or the individual's personal agent about the environmental accessibility adaptation required to meet the individual's needs.

(39) "Exit" means termination or discontinuance of:

(a) Services from a service provider; or

(b) Department-funded developmental disability services.

(40) "Family" for determining individual eligibility for brokerage services as a resident in the family home and for determining who may receive family training, means a unit of two or more persons that include at least one individual with an intellectual or developmental disability where the primary caregiver is:

(a) Related to the individual with an intellectual or developmental disability by blood, marriage, or legal adoption; or

(b) In a domestic relationship where partners share:

(A) A permanent residence;

(B) Joint responsibility for the household in general (e.g. child-rearing, maintenance of the residence, basic living expenses); and

(C) Joint responsibility for supporting the individual with an intellectual or developmental disability when the individual is related to one of the partners by blood, marriage, or legal adoption.

(41) "Family Training" means training and counseling services for the family of an individual that increase the family's capacity to care for, support, and maintain the individual in the home as described in OAR 411-340-0130. Family training includes:

(a) Instruction about treatment regimens and use of equipment specified in the Individual Support Plan;

(b) Information, education, and training about the individual's intellectual or developmental disability, medical, and behavioral conditions; and

(c) Counseling for the family to relieve the stress associated with caring for an individual with intellectual or developmental disabilities.

(42) "Fiscal Intermediary" means a person or entity that receives and distributes support services funds on behalf of an individual who employs persons to provide services, supervision, or training in the home or community according to the Individual Support Plan.

(43) "Founded Reports" means the Department's or Law Enforcement Authority's (LEA) determination, based on the evidence, that there is reasonable cause to believe that conduct in violation of the child abuse statutes or rules has occurred and such conduct is attributable to the person alleged to have engaged in the conduct.

(44) "Functional Needs Assessment (FNAT)" means an assessment that documents the level of need, accommodates an individual's participation in service planning, and includes:

(a) Completing a comprehensive and holistic assessment;

(b) Surveying physical, mental, and social functioning; and

(c) Identifying risk factors, choices and preferences, and service needs.

(45) "General Business Provider" means an organization or entity selected by an individual or the individual's legal representative, and paid with support services funds that:

(a) Is primarily in business to provide the service chosen by the individual to the general public;

(b) Provides services for the individual through employees, contractors, or volunteers; and

(c) Receives compensation to recruit, supervise, and pay the persons who actually provide support for the individual.

(46) "Habilitation Services" mean services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

(47) "Hearing" means the formal process following an action that would terminate, suspend, reduce, or deny a service. This is a formal process required by federal law (42 CFR 431.200-250). A hearing is also known as a Medicaid Fair Hearing and contested case hearing.

(48) "Home" means an individual's primary residence that is not under contract with the Department to provide services to an individual as a licensed or certified foster home, residential care facility, assisted living facility, nursing facility, or other residential support program site.

(49) "Home and Community-Based Waivered Services" mean the services approved by the Centers for Medicare and Medicaid Services in accordance with Sections 1915(c) and 1115 of the Social Security Act.

(50) "Incident Report" means a written report of any unusual incident involving an individual.

(51) "Independence" means the extent to which individuals with intellectual or developmental disabilities exert control and choice over their own lives.

(52) "Independent Provider" means a person selected by an individual or the individual's legal representative and paid with support services funds that personally provide services to the individual.

(53) "Individual" means an adult with intellectual or developmental disabilities for whom services are planned and provided.

(54) "Individual Cost Limit" means the maximum annual benefit level available under the Support Services Waiver version OR.0375.R02.03. The support services waiver may be obtained by contacting the Department of Human Services, Developmental Disabilities, ATTN: Rule Coordinator, 500 Summer Street NE, E-10, Salem, Oregon 97301.

(55) "Individual Support Plan (ISP)" means the written details of the supports, activities, costs, and resources required for an individual to achieve personal outcomes and be supported by the family in the family home. An individual's support needs are identified through a functional needs assessment. The manner in which services are delivered, service providers, and the frequency of services are reflected in an ISP. The ISP is developed at minimum annually to reflect decisions and agreements made during a person-centered process of planning and information gathering. An individual's ISP is the only plan of care required by the Department for an individual receiving in-home supports.

(56) "Instrumental Activities of Daily Living (IADL)" mean those activities, other than activities of daily living, required to continue independent living.

(57) "Integration" as defined in ORS 427.005 means:

(a) The use by individuals with intellectual or developmental disabilities of the same community resources used by and available to other persons;

(b) Participation by individuals with intellectual or developmental disabilities in the same community activities in which persons without an intellectual or developmental disability participate, together with regular contact with persons without an intellectual or developmental disability; and

(c) Individuals with intellectual or developmental disabilities reside in homes or home-like settings that are in proximity to community resources and foster contact with persons in their community.

(58) "Intellectual Disability" has the meaning set forth in OAR 411-320-0020 and described in OAR 411-320-0080.

(59) "Legal Representative" means an attorney at law who has been retained by or for an individual or a person or agency authorized by the court to make decisions about services for the individual.

(60) "Level of Care" means an assessment completed by a services coordinator has determined an individual meets institutional level of care. An individual meets institutional level of care for an intermediate care facility for individuals with intellectual or developmental disabilities if:

(a) The individual has a condition of an intellectual disability or a developmental disability as defined in OAR 411-320-0020 and meets the eligibility criteria for developmental disability services as described in 411-320-0080; and

(b) The individual has a significant impairment in one or more areas of adaptive functioning. Areas of adaptive functioning include self direction, self care, home living, community use, social, communication, mobility, or health and safety.

(61) "Mandatory Reporter" means any public or private official as defined in OAR 407-045-0260 who, while acting in an official capacity, comes in contact with and has reasonable cause to believe an adult with an intellectual or developmental disability has suffered abuse, or comes in contact with any person whom the official has reasonable cause to believe abused an adult with an intellectual or developmental disability. Nothing contained in ORS 40.225 to 40.295 affects the duty to report imposed by this section of this rule, except that a psychiatrist, psychologist, clergy, or attorney is not required to report if the communication is privileged under 40.225 to 40.295.

(62) "Medication" means any drug, chemical, compound, suspension, or preparation in suitable form for use as a curative or remedial substance taken either internally or externally by any person.

(63) "Natural Supports" or "Natural Support System" means the resources available to an individual from their relatives, friends, significant others, neighbors, roommates, and the community. Services provided by natural supports are resources that are not paid for by the Department.

(64) "Nurse" means a person who holds a current license from the Oregon Board of Nursing as a registered nurse or licensed practical nurse pursuant to ORS chapter 678.

(65) "Nursing Care Plan" means a plan developed by a registered nurse that describes the medical, nursing, psychosocial, and other needs of the individual and how those needs are met. The Nursing Care Plan includes the tasks that are taught, assigned, or delegated to the qualified provider or family.

(66) "Occupational Therapy" means the services described in OAR 411-340-0130 provided by a professional licensed under ORS 675.240 that are defined under the approved State Medicaid Plan, except that the amount, duration, and scope specified in the State Medicaid Plan do not apply.

(67) "OSIP-M" means Oregon Supplemental Income Program-Medical as defined in OAR 461-101-0010. OSIPM is Oregon Medicaid insurance coverage for individuals who meet eligibility criteria as described in OAR chapter 461.

(68) "Personal Agent" means a person who works directly with individuals and families to provide or arrange for support services as described in these rules, is a case manager for the provision of case management services, meets the qualifications set forth in OAR 411-340-0150(5), and is:

(a) A trained employee of a brokerage; or

(b) A person who has been engaged under contract to the brokerage to allow the brokerage to meet responsibilities in geographic areas where personal agent resources are severely limited.

(69) "Personal Care Services" means assistance with activities of daily living, instrumental activities of daily living, and health-related tasks through cueing, monitoring, reassurance, redirection, set-up, hands-on, standby assistance, and reminding.

(70)"Personal Support Worker":

(a) Means a person:

(A) Who is hired by an individual with an intellectual or developmental disability or the individual's legal representative;

(B) Who receives money from the Department for the purpose of providing personal care services to the individual in the individual's home or community; and

(C) Whose compensation is provided in whole or in part through the Department or community developmental disability program.

(b) This definition of personal support worker is intended to reflect the term as defined in ORS 410.600.

(71) "Person-Centered Planning" means:

(a) A process, either formal or informal, for gathering and organizing information that helps an individual:

(A) Determine and describe choices about personal goals, activities, and lifestyle preferences;

(B) Design strategies and networks of support to achieve goals and a preferred lifestyle using individual strengths, relationships, and resources; and

(C) Identify, use, and strengthen naturally occurring opportunities for support at home and in the community.

(b) The methods for gathering information vary, but all are consistent with individual needs and preferences.

(72) "Physical Therapy" means the services described in OAR 411-340-0130 provided by a professional licensed under ORS 688.020 that are defined under the approved State Medicaid Plan, except that the amount, duration, and scope specified in the State Medicaid Plan do not apply.

(73) "Plan Year" means 12 consecutive months that, unless otherwise set according to the conditions of OAR 411-340-0120, begins on the start date specified on the individual's first authorized Individual Support Plan (ISP) after entry to a brokerage. Subsequent plan years begin on the anniversary of the start date of the initial ISP.

(74) "Positive Behavioral Theory and Practice" means a proactive approach to individual behavior and behavior interventions that:

(a) Emphasizes the development of functional alternative behavior and positive behavior intervention;

(b) Uses the least intervention possible;

(c) Ensures that abusive or demeaning interventions are never used; and

(d) Evaluates the effectiveness of behavior interventions based on objective data.

(75) "Prescription Medication" means any medication that requires a physician prescription before it may be obtained from a pharmacist.

(76) "Prevocational Services" are services described in OAR 411-340-0130 that are not job-task oriented that are aimed at preparing an individual with an intellectual or developmental disability for paid or unpaid employment. Prevocational services include teaching such concepts as compliance, attendance, task completion, problem solving, and safety. Prevocational services are provided to individuals not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year.

(77) "Primary Caregiver" means the person identified in an Individual Support Plan as providing the majority of service and support for an individual in the individual's home.

(78) "Productivity" as defined in ORS 427.005 means:

(a) Engagement in income-producing work by an individual with intellectual or developmental disabilities that is measured through improvements in income level, employment status, or job advancement; or

(b) Engagement by an individual with intellectual or developmental disabilities in work contributing to a household or community.

(79) "Protection" and "Protective Services" mean necessary actions taken as soon as possible to prevent subsequent abuse or exploitation of an individual, to prevent self-destructive acts, and to safeguard an individual's person, property, and funds.

(80) "Provider Organization" means an entity selected by an individual or the individual's representative, and paid with support services funds that:

(a) Is primarily in business to provide supports for individuals with intellectual or developmental disabilities;

(b) Provides supports for the individual through employees, contractors, or volunteers; and

(c) Receives compensation to recruit, supervise, and pay the persons who actually provide support for the individual.

(81) "Provider Organization Director" means the employee of a provider organization, or the employee's designee, responsible for administration and provision of services according to these rules.

(82) "Psychotropic Medication" means a medication the prescribed intent of which is to affect or alter thought processes, mood, or behavior including but not limited to anti-psychotic, antidepressant, anxiolytic (anti-anxiety), and behavior medications. The classification of a medication depends upon its stated, intended effect when prescribed.

(83) "Quality Assurance" means a systematic procedure for assessing the effectiveness, efficiency, and appropriateness of services.

(84) "Rate Guidelines" mean the guidelines for rates and limits paid for some support services. The Department's support services rate guidelines as of April 1, 2013 are maintained on the Department's website (http://www.dhs.state.or.us/spd/tools/dd/bpa/rate-guidelines-040113.pdf). Printed copies may be obtained by contacting the Department of Human Services, Developmental Disabilities, ATTN: Rule Coordinator, 500 Summer Street NE, E-10, Salem, Oregon 97301.

(85) "Regional Crisis Diversion Program" means the regional coordination of the management of crisis diversion services for a group of designated counties that is responsible for the management of the following developmental disability services:

(a) Crisis intervention services;

(b) Evaluation of requests for new or enhanced services for certain groups of individuals eligible for developmental disability services; and

(c) Other developmental disability services that the counties comprising the region agree are more effectively or automatically delivered on a regional basis.

(86) "Representative" means a person selected by an individual or the individual's legal representative to act on the individual's behalf to direct the individual's Individual Support Plan.

(87) "Respite" means intermittent services as described in OAR 411-340-0130 provided on a periodic basis, but not more than 14 consecutive days, for the relief of, or due to the temporary absence of, a person normally providing supports to an individual with an intellectual or developmental disability unable to care for him or herself.

(88) "Restraint" means any physical hold, device, or chemical substance that restricts, or is meant to restrict, the movement or normal functioning of an individual.

(89) "Self-Administration of Medication" means the individual manages and takes his or her own medication, identifies his or her medication and the times and methods of administration, places the medication internally in or externally on his or her own body without staff assistance upon written order of a physician, and safely maintains the medication without supervision.

(90) "Self-Determination" means a philosophy and process by which individuals with intellectual or developmental disabilities are empowered to gain control over the selection of support services that meet their needs. The basic principles of self-determination are:

(a) Freedom. The ability for an individual with an intellectual or developmental disability, together with freely-chosen family and friends, to plan a life with necessary support services rather than purchasing a predefined program;

(b) Authority. The ability for an individual with an intellectual or developmental disability, with the help of a social support network if needed, to control a certain sum of resources in order to purchase support services;

(c) Autonomy. The arranging of resources and personnel, both formal and informal, that assists an individual with an intellectual or developmental disability to live a life in the community rich in community affiliations; and

(d) Responsibility. The acceptance of a valued role in an individual's community through competitive employment, organizational affiliations, personal development, and general caring for others in the community, as well as accountability for spending public dollars in ways that are life-enhancing for individuals with intellectual or developmental disabilities.

(91) "Skills Training" means activities intended to increase an individual's independence through training, coaching, and prompting the individual to accomplish activities of daily living, instrumental activities of daily living, and health-related skills as described in OAR 411-340-0130.

(92) "Social Benefit" means a service or financial assistance solely intended to assist an individual with an intellectual or developmental disability to function in society on a level comparable to that of a person who does not have such an intellectual or developmental disability. Social benefits are pre-authorized by an individual's services coordinator and provided according to the description and financial limits written in an Individual Support Plan.

(a) Social benefits may not:

(A) Duplicate benefits and services otherwise available to persons regardless of intellectual or developmental disability;

(B) Provide financial assistance with food, clothing, shelter, and laundry needs common to persons with or without intellectual or developmental disabilities; or

(C) Replace other governmental or community services available to an individual.

(b) Financial assistance provided as a social benefit may not exceed the actual cost of the support required by an individual to be supported in the individual's home and must be either:

(A) Reimbursement for an expense previously authorized in an Individual Support Plan (ISP); or

(B) An advance payment in anticipation of an expense authorized in a previously authorized ISP.

(93) "Special Diet" means specially prepared food or particular types of food, ordered by a physician and periodically monitored by a dietician, specific to an individual's medical condition or diagnosis that are needed to sustain an individual in the individual's home. Special diets are supplements and are not intended to meet an individual's complete daily nutritional requirements. Special diets may include:

(a) High caloric supplements;

(b) Gluten-free supplements; and

(c) Diabetic, ketogenic, or other metabolic supplements.

(94) "Specialized Equipment and Supplies" mean the devices, aids, controls, supplies, or appliances that enable individuals to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live as described in OAR 411-340-0130. Specialized medical equipment and supplies include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the State Medicaid Plan. Specialized medical equipment and supplies may not include items not of direct medical or remedial benefit to the individual. Specialized medical equipment and supplies must meet applicable standards of manufacture, design, and installation.

(95) "Specialized Supports" mean treatment, training, consultation, or other unique services provided by a social or sexual consultant to achieve outcomes in an Individual Support Plan that are not available through State Medicaid Plan services or other support services listed in OAR 411-340-0130. Specialized supports include:

(a) Assessing the needs of the individual and family, including environmental factors;

(b) Developing a plan of support;

(c) Training caregivers to implement the plan of support;

(d) Monitoring implementation of the plan of support; and

(e) Revising the plan of support as needed.

(96) "Speech, Hearing, and Language Services" mean the services as described in OAR 411-340-0130 provided by a professional licensed under ORS 681.250 that are defined under the approved State Medicaid Plan, except that the amount, duration, and scope specified in the State Medicaid Plan do not apply.

(97) "Substantiated" means an abuse investigation has been completed by the Department or the Department's designee and the preponderance of the evidence establishes the abuse occurred.

(98) "Support" means the assistance that an individual requires, solely because of the affects of intellectual or developmental disability, to maintain or increase independence, achieve community presence and participation, and improve productivity. Support is flexible and subject to change with time and circumstances.

(99) "Supported Employment Services" means provision of job training and supervision available to assist an individual who needs intensive ongoing support to choose, get, and keep a job in a community business setting. Supported employment is a service planned in partnership with public vocational assistance agencies and school districts and through Social Security Work Incentives when available.

(100) "Support Services" mean the services of a brokerage listed in OAR 411-340-0120 as well as the uniquely determined activities and purchases arranged through the brokerage support services that:

(a) Complement the existing formal and informal supports that exist for an individual living in the individual's own home or family home;

(b) Are designed, selected, and managed by the individual or the individual's representative;

(c) Are provided in accordance with an Individual Support Plan; and

(d) May include purchase of supports as a social benefit required for an individual to live in the individual's home or the family home.

(101) "Support Services Brokerage" or "Brokerage" means an entity, or distinct operating unit within an existing entity, that uses the principles of self-determination to perform the functions listed in OAR 411-340-0120(1) associated with planning and implementation of support services for individuals with intellectual or developmental disabilities.

(102) "Support Services Brokerage Director" or "Brokerage Director" means the employee of a publicly or privately-operated brokerage, or that person's designee, who is responsible for administration and provision of services according to these rules.

(103) "Support Services Brokerage Plan of Care Crisis Addendum" means the short-term plan that is required by the Department to be added to an Individual Support Plan to describe crisis diversion services an individual is to receive while the individual is in emergent status in a short-term residential placement.

(104) "Support Services Brokerage Policy Oversight Group" or "Policy Oversight Group" means the group that meets the requirements of OAR 411-340-0150(1) that is formed to provide consumer-based leadership and advice to each brokerage regarding issues such as development of policy, evaluation of services, and use of resources.

(105) "Support Services Expenditure Guideline" means a publication of the Department that describes allowable uses for support services funds.

(106) "Support Services Funds" mean public funds designated by the brokerage for assistance with the purchase of supports according to each Individual Support Plan.

(107) "These Rules" mean the rules in OAR chapter 411, division 340.

(108) "Transition Costs" mean expenses such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility or intermediate care facility for the intellectually disabled to a community-based home setting where the individual resides as described in OAR 411-340-0130.

(109) "Transportation" means services as described in OAR 411-340-0130 that allow individuals to gain access to community services, activities, and resources that are not medical in nature.

(110) "Unusual Incident" means incidents involving serious illness or accidents, death of an individual, injury or illness of an individual requiring inpatient or emergency hospitalization, suicide attempts, a fire requiring the services of a fire department, an act of physical aggression, or any incident requiring an abuse investigation.

(111) "Volunteer" means any person assisting a service provider without pay to support the services provided to an individual.

Stat. Auth.: ORS 409.050 & 410.070

Stats. Implemented: ORS 427.005, 427.007, 430.610 - 430.695

Hist.: MHD 9-2001(Temp), f. 8-30-01, cert. ef. 9-1-01 thru 2-27-02; MHD 5-2002, f. 2-26-02 cert. ef. 2-27-02; MHD 4-2003(Temp); f. & cert. ef. 7-1-03 thru 12-27-03; Renumbered from 309-041-1760, SPD 22-2003, f. 12-22-03, cert. ef. 12-28-03; SPD 38-2004(Temp), f. 12-30-04, cert. ef. 1-1-05 thru 6-30-05; SPD 8-2005, f. & cert. ef. 6-23-05; SPD 17-2006, f. 4-26-06, cert. ef. 5-1-06; SPD 21-2007(Temp), f. 12-31-07, cert. ef. 1-1-08 thru 6-29-08; SPD 8-2008, f. 6-27-08, cert. ef. 6-29-08; SPD 8-2009, f. & cert. ef. 7-1-09; SPD 25-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SPD 5-2010, f. 6-29-10, cert. ef. 7-1-10; SPD 27-2011, f. & cert. ef. 12-28-11; SPD 3-2013(Temp), f. 3-20-13, cert. ef. 4-1-13 thru 9-28-13; SPD 30-2013(Temp), f. & cert. ef. 7-2-13 thru 9-28-13

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Department of Human Services,
Self-Sufficiency Programs
Chapter 461

Rule Caption: Changing OARs affecting public assistance, medical assistance, or Supplemental Nutrition Assistance Program clients

Adm. Order No.: SSP 13-2013

Filed with Sec. of State: 7-1-2013

Certified to be Effective: 7-1-13

Notice Publication Date: 5-1-2013

Rules Amended: 461-115-0430, 461-130-0310, 461-135-0070, 461-135-0400, 461-135-0900, 461-145-0250, 461-150-0060, 461-155-0150, 461-155-0180, 461-155-0710, 461-160-0040, 461-175-0222, 461-193-0320, 461-195-0521, 461-195-0541

Rules Repealed: 461-155-0180(T), 461-195-0541(T)

Subject: OAR 461-115-0430 about periodic redeterminations is being amended to state that benefits Temporary Assistance for Needy Families (TANF) end on the last day of the certification period.

OAR 461-130-0310 about the exempt, mandatory, and volunteer participation classifications is being amended to expand who is required to participate in the JOBS program as a condition of receiving benefits in the Refugee and TANF program. The expanded mandate includes caretaker relatives as well caretaker relatives when there is a pregnancy but no dependent child.

OAR 461-135-0070 about eligibility requirements for Temporary Assistance for Needy Families (TANF) is being amended to expand who is eligible for TANF when there is a pregnancy in the family.

OAR 461-135-0400 about specific requirements in the Employment Related Day Care (ERDC) program is being amended to make permanent a temporary rule change effective January 1, 2013 specifying the requirement for verification if eligibility is based on an unemployed adult being physically or mentally unable to provide adequate child care when there are two adults in the filing group (the individuals whose circumstances are considered in the eligibility process).

OAR 461-135-0900 and 461-193-0320 are being amended to increase cash assistance for refugees who are receiving Refugee Assistance program (REF) benefits by not prorating the first month of assistance; and to clarify under what circumstances non-proration of the first month of REF assistance will occur. OAR 461-135-0900 is also being amended to clarify the impact of TANF program eligibility on REF program eligibility and the impact of eligibility for other medical assistance programs on eligibility for the REFM (Refugee Assistance Medical) program.

OAR 461-145-0250 about how income producing property affects income for several Department programs is being amended to clarify how to treat income received from property for the SNAP program. The rule does not currently address how to calculate the income when an individual has more than one property for income that is not self-employment income (when the individual is managing the property less than 20 hours each week) Under this amendment, the exclusions for one property may not be used to offset income from a different property.

OAR 461-150-0060 about prospective budgeting and eligibility is being amended to limit the use of actual income to the initial month of eligibility for the Refugee and Temporary Assistance for Needy Families (TANF) programs when actual income does not reflect later months in the certification period.

OAR 461-155-0150 about child care eligibility standard, payment rates, and copayments is being amended to adjust the policy in place under a temporary rule change effective January 1, 2013 and broaden the sources of acceptable documentation required to verify the special needs rate eligibility of a child. This rule is also being amended to remove the requirement that a provider can only bill for an absent day if they were unable to fill the absent child's slot with another child.

OAR 461-155-0180 about the poverty related income standards is being amended to identify for the SNAP program the standard amounts representing 185 percent of the federal poverty level for 2013. This increase went into effect February 1, 2013 and is currently covered under the temporary rule.

OAR 461-155-0710 about diversion and transition Services in the Oregon Supplemental Income Program (OSIP) and Oregon Supplemental Income Program Medical (OSIPM) is being amended to remove the requirement that payments authorized by this rule be approved by Senior and People with Disabilities Division central office staff.

OAR 461-160-0040 about the deduction and coverage dependent care costs is being amended to state the policy about when job search can lead to allowable child care costs in the Employment Related Day Care (ERDC) program. This rule supersedes prior DHS policies on this topic in the Family Services Manual.

OAR 461-175-0222 about notice requirements at the expiration of a certification period is being amended to include notice requirements for expiration of the certified eligibility period for Temporary Assistance for Needy Families (TANF) benefits.

OAR 461-195-0521 about the calculation of overpayments is being amended to state that in the ERDC, MAA, MAF, REF, SNAP, and TANF programs a client's actual self-employment income

should be annualized retrospectively to calculate an overpayment. This rule is also being amended to clarify how earned income deductions are treated in the context of an overpayment.

OAR 461-195-0541 about liability overpayments is being amended to clarify the age of adults who are liable for overpayments in the SNAP program.

Rules Coordinator: Annette Tesch—(503) 945-6067

461-115-0430

Periodic Redeterminations; Not EA, ERDC, EXT, OHP, REF, REFM, SNAP, or TA-DVS

The Department periodically redetermines the eligibility of clients for benefits and assigns a redetermination date by which the next determination is required. The Department selects the redetermination date based on the client's circumstances and according to the following requirements:

(1) In the BCCM, GA, GAM, and HKC programs, the Department determines eligibility each 12 months.

(2) In the MAA, MAF, and SAC programs, the Department redetermines eligibility at least once every 12 months.

(3) In the OSIP and OSIPM programs, the Department determines eligibility each 12 months for clients who are not eligible for SSI. No redetermination is required for clients who are eligible for SSI.

(4) In the QMB program, the Department determines eligibility each 12 months for clients who are not eligible for SSI. For QMB recipients who are also eligible for MAA, MAF or OSIPM, a redetermination for QMB is completed with the redetermination of the other program.

(5) In the SFPSS program, the Department redetermines eligibility at least once every 12 months. The Department redetermines program eligibility by redetermining eligibility for the TANF program.

(6) In the TANF program, benefits will end the last day of the certification period (see OAR 461-001-0000). The Department redetermines eligibility according to the following schedule:

(a) At least once every six months for each of the following:

(A) Clients not participating in an activity (see OAR 461-001-0025) of an open case plan (see OAR 461-001-0025).

(B) Clients who are currently serving a JOBS disqualification.

(b) At least once every 12 months for all other clients.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.704, 411.706, 412.014, 412.049, 414.025, 414.231, 414.826, 414.831, 414.839

Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.704, 411.706, 412.014, 412.049, 414.025, 414.231, 414.826, 414.831, 414.839

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 12-1990, f. 3-30-90, cert. ef. 4-1-90; AFS 20-1990, f. 8-17-90, cert. ef. 9-1-90; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 2-1992, f. 1-30-92, cert. ef. 2-1-92; AFS 8-1992, f. & cert. ef. 4-1-92; AFS 20-1992, f. 7-31-92, cert. ef. 8-1-92; AFS 12-1993, f. & cert. ef. 7-1-93; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 23-1994, f. 9-29-94, cert. ef. 10-1-94; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 23-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 26-1996, f. 6-27-96, cert. ef. 7-1-96; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 3-1997, f. 3-31-97, cert. ef. 4-1-97; AFS 9-1999, f. & cert. ef. 7-1-99; AFS 11-1999, f. & cert. ef. 10-1-99; AFS 22-2001, f. & cert. ef. 10-1-01; AFS 5-2002, f. & cert. ef. 4-1-02; AFS 13-2002, f. & cert. ef. 10-1-02; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 11-2007(Temp), f. & cert. ef. 10-1-07 thru 3-29-08; SSP 5-2008, f. 2-29-08, cert. ef. 3-1-08; SSP 39-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SSP 5-2010, f. & cert. ef. 4-1-10; SSP 7-2010(Temp), f. & cert. ef. 4-1-10 thru 6-30-10; SSP 18-2010, f. & cert. ef. 7-1-10; SSP 37-2012, f. 12-28-12, cert. ef. 1-1-13; SSP 13-2013, f. & cert. ef. 7-1-13

461-130-0310

Participation Classifications: Exempt, Mandatory, and Volunteer

(1) In the Post-TANF, Pre-TANF, REF, SNAP, and TANF programs:

(a) The Department assigns a client to one or more employment program participation classifications--exempt, mandatory, and volunteer (see OAR 461-130-0305 for definitions of all three terms).

(b) In the Post-TANF program, a client is classified as a volunteer.

(2) In the Pre-TANF, REF, and TANF programs:

(a) A client is exempt from employment program participation and disqualification if the client meets the requirements of at least one of the following paragraphs. The client is:

(A) Pregnant and in the month before the month in which the due date of the pregnancy falls.

(B) A parent (see OAR 461-001-0000) during the first six months after the birth of the parent's dependent child (see OAR 461-001-0000) except that the Department may require the parent to participate in parenting classes or a family stability activity (see OAR 461-001-0000). An exemption allowed under this paragraph may apply only to one mandatory participant in each filing group.

(C) Under 20 years of age during the first 16 weeks after giving birth except that the client may be required to participate in suitable activities with a preference for educational activities, parenting classes, and family stability activity.

(D) A parent providing care for a family member who is an individual with a disability (see OAR 461-001-0000) and is in the household group (see OAR 461-110-0210) with the parent. Medical documentation to support the need for the care is required.

(E) An REF client 65 years of age or older.

(F) A TANF client 60 years of age or older.

(G) A noncitizen who is not authorized to work in the United States.

(H) An individual who is eligible for and receives supplemental security income (SSI) from the Social Security Administration.

(I) A caretaker relative (see OAR 461-001-0000) who is non-needy.

(J) A client whose participation is likely to cause undue hardship or is contrary to the best interests of the dependent child or needy caretaker relative.

(K) A pregnant client who participates more than 10 hours per week during the two months before the month in which the pregnancy due date falls.

(L) A VISTA volunteer.

(b) A caretaker relative of a dependent child or unborn who receives REF or TANF program benefits is mandatory if the caretaker relative is in the same filing group (see OAR 461-110-0330) with the dependent child or unborn (even if the caretaker relative is not in the REF or TANF program benefit group under OAR 461-110-0750), unless the caretaker relative is otherwise exempt from participation under subsection (a) of this section.

(3) In the SNAP program:

(a) A client is exempt from employment program participation and disqualification if the client meets the requirements of one of the following paragraphs. The client is:

(A) Working a minimum of 30 hours a week or earning money equal to at least the federal minimum wage multiplied by 30 hours per week multiplied by 4.3 weeks. A self-employed client with allowable costs must meet the earnings threshold after allowing the 50 percent deduction. This includes migrant and seasonal farm workers (see OAR 461-001-0015) who are under contract or similar agreement with an employer or crew chief to begin employment within 30 days.

(B) An individual with a physical or mental condition that prevents performance of any work.

(C) Responsible for the care of a child in the household under 6 years of age or an individual in the household with a disability (see OAR 461-001-0015) that substantially reduces or eliminates the individual's ability to care for himself or herself.

(D) Providing care for at least 30 hours a week for an individual in another household with a disability (see OAR 461-001-0015) that substantially reduces or eliminates the individual's ability to care for himself or herself.

(E) Enrolled at least half-time, as defined by the school, in any high school or equivalent program recognized by a school district or enrolled at least half-time in any school, training program, or institution of higher education. Clients remain exempt during normal periods of class attendance, vacation and recess but no longer qualify for the student exemption when a break in enrollment occurs due to graduation, suspension or expulsion or when the student drops out of school or does not enroll in classes for the next regular school term (excluding summer term).

(F) Receiving REF or TANF program benefits, while a mandatory participant in the JOBS or NAES programs.

(G) In receipt of unemployment insurance benefits or has completed an application for unemployment insurance benefits and is waiting for an initial decision on the claim.

(H) Participating in a drug or alcohol treatment and rehabilitation program.

(I) Pregnant.

(J) Lacking adequate dependent care.

(K) Without adequate transportation available.

(L) Experiencing a barrier to employment, such as being homeless or having a short-term physical or mental limitation or a serious family problem.

(b) A mandatory client is an individual in the need group (see OAR 461-110-0630); who is 16 or 17 years of age and a primary person (see OAR 461-001-0015), or 18 years of age and older and 59 years of age and younger; and who is not exempt under subsection (a) of this section.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.660, 411.710, 411.816, 412.006, 412.009, 412.014 & 412.049

Stats. Implemented: ORS 409.010, 411.060, 411.070, 411.710, 411.816, 412.006, 412.009, 412.014, 412.049 & 2011 OL 604

Hist.: AFS 17-1998, f. & cert. ef. 10-1-98; AFS 9-1999, f. & cert. ef. 7-1-99; AFS 12-2000(Temp), f. 5-1-00, cert. ef. 5-1-00 thru 9-30-00; AFS 25-2000, f. 9-29-00, cert. ef. 10-1-00; AFS 34-2000, f. 12-22-00, cert. ef. 1-1-01; SSP 14-2005, f. 9-30-05, cert. ef. 10-1-05; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 11-2007(Temp), f. & cert. ef. 10-1-07 thru 3-29-08; SSP 5-2008, f. 2-29-08, cert. ef. 3-1-08; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 28-

2009, f. & cert. ef. 10-1-09; SSP 41-2010, f. 12-30-10, cert. ef. 1-1-11; SSP 18-2011(Temp), f. & cert. ef. 7-1-11 thru 12-28-11; SSP 25-2011, f. 9-30-11, cert. ef. 10-1-11; SSP 39-2012(Temp), f. 12-28-12, cert. ef. 1-1-13 thru 6-30-13; SSP 8-2013, f. & cert. ef. 4-1-13; SSP 13-2013, f. & cert. ef. 7-1-13

461-135-0070
Specific Requirements; MAA, MAF, and TANF

(1) To be eligible for MAA, MAF, or TANF program benefits, a client must be one of the following:

(a) A dependent child (see OAR 461-001-0000). However, a dependent child for whom foster care payments are made for more than 30 days is not eligible while the payments are being made for the dependent child.

(b) A caretaker relative (see OAR 461-001-0000) of an eligible dependent child. However, a caretaker relative to whom foster care payments are made for more than 30 days is not eligible while the payments are being made to the caretaker relative.

(c) A caretaker relative of a dependent child, when the dependent child is ineligible for MAA, MAF, or TANF program benefits because of one of the following reasons:

(A) The child is receiving SSI.

(B) The child is in foster care, but is expected to return home within 30 days.

(C) The child is ineligible for MAA or MAF program benefits because citizenship has not been documented (see OAR 461-115-0705).

(d) An essential person. An essential person is a member of the household group (see OAR 461-110-0210) who:

(A) Is not required to be in the filing group;

(B) Provides a service necessary to the health or protection of a member of the benefit group (see OAR 461-110-0750) who has a mental or physical disability; and

(C) Is less expensive to include in the benefit group than the cost of purchasing this service from another source.

(e) A parent (see OAR 461-001-0000) of an unborn, as follows:

(A) For the TANF and MAA programs, any parent whose only child is an unborn child once the mother's pregnancy has reached the calendar month before the month in which the due date falls.

(B) For the MAA program, the father of an unborn child, if there is another dependent child in the filing group.

(C) For the TANF program, the parent of an unborn child, if there is another dependent child in the filing group (see OAR 461-110-0330).

(D) For the MAF program, a mother whose only child is an unborn once the mother's pregnancy has reached the calendar month immediately before the month in which the due date falls.

(2) A client is eligible for MAA or MAF program benefits if the client is:

(a) Eligible for MAA or MAF program benefits under OAR 461-135-0010; or

(b) A minor parent (see OAR 461-001-0000) ineligible for TANF program benefits only because:

(A) The minor refuses to live with a parent or legal guardian as required by OAR 461-135-0080; or

(B) The income of the minor exceeds the income standards because the Department required the minor to return to live with a parent, if the minor parent meets the conditions in OAR 461-135-0080(2).

(3) As used in this rule and OAR 461-125-0170:

(a) Except as provided otherwise in this section, "good cause" means a reasonable person of normal sensitivity, exercising ordinary common sense under similar circumstances, would have:

(A) Left work; or

(B) Participated in behavior leading to the individual's discharge or to the individual quitting work in anticipation of discharge.

(b) For an individual with a physical or mental impairment (as defined at 29 CFR 1630.2(h)), except as provided otherwise in subsection (c) of this section, "good cause" for leaving work means that a reasonable person with the characteristics and qualities of such individual under similar circumstances would have:

(A) Left work;

(B) Participated in behavior leading to the individual's discharge; or

(C) Quit work in anticipation of a discharge.

(c) There is no "good cause" if the reason for separation from employment is a labor dispute.

(4) Except as provided under section (5) of this rule, a need group (see OAR 461-110-0630) is not eligible for TANF program benefits for 120 days from the date a caretaker relative was separated from his or her last employment in which the caretaker relative in the need group was hired to work 100 or more hours per month or worked or was scheduled to work 100 or more hours in the last full calendar month of employment.

(5) A need group (see OAR 461-110-0630) may not be denied TANF program benefits based on section (4) of this rule, or based on not meeting OAR 461-125-0170(1)(c) or (d), if the caretaker relative is one of the following:

(a) A Parents as Scholars (PAS) participant who temporarily becomes ineligible for TANF program benefits for four months or less due to income from a paid work experience (see OAR 461-190-0199).

(b) A teen parent (see OAR 461-001-0000) returning to high school or equivalent.

(c) An individual fleeing from or at risk of domestic violence (see OAR 461-001-0000).

(d) An individual in the ninth month of pregnancy or experiencing a medical complication due to the pregnancy which is documented by a qualified and appropriate professional.

(e) An individual unable to work due to a disability or medical condition documented by a qualified and appropriate professional, and which is expected to last for 30 days or more from the date of request (see OAR 461-115-0030) for TANF program benefits.

(f) An individual who was separated from employment for a reason the Department determines is good cause.

(g) An individual who was separated from employment as a result of a layoff.

(6) If the need group is not eligible for TANF program benefits solely under section (4) of this rule, the need group is eligible for MAA or MAF program benefits as long as the need group meets all other eligibility (see OAR 461-001-0000) requirements.

(7) A client is eligible for MAF program benefits even while ineligible for TANF program benefits if the client is ineligible for TANF program benefits only because the client is:

(a) A family who would be eligible for the TANF program benefits if allowed the following deductions from income:

(A) The earned income deductions authorized by OAR 461-160-0190.

(B) The unearned income support deduction authorized by OAR 461 160 0200.

(b) A self-employed family who would be eligible for TANF program benefits if the cost of producing the self-employment income was subtracted from the gross sales or receipts under OAR 461-145-0920.

(c) A family that includes an ineligible non-citizen or the father of an unborn who would be eligible for TANF program benefits if the ineligible non-citizen's or father's income is counted under OAR 461-160-0120.

(d) An individual who would be eligible for TANF program benefits if the assets of the following household members were not counted:

(A) An unmarried parent of a dependent child or unborn in the eligibility group.

(B) A child in common of parents in the eligibility group.

(C) The spouse and each child of a caretaker relative in the need group.

(e) The spouse of a caretaker relative, but only if the spouse is the parent of a dependent child.

(8) A family is ineligible for TANF program benefits if the family meets the requirements of all of the following subsections:

(a) The family lives in Klamath County.

(b) The family meets any of the following conditions:

(A) The family has a single custodial parent who is a member of the Klamath Tribes, or the single custodial parent is not a Klamath Tribes member and at least 50 percent of the dependent children are Klamath Tribes members;

(B) The family has two custodial parents (see OAR 461-001-0000) who are members of the Klamath Tribes, or only one of the two custodial parents is a Klamath Tribes member and at least 50 percent of the dependent children are Klamath Tribes members; or

(C) The family has a caretaker relative who is not the custodial parent and at least 50 percent of the dependent children are Klamath Tribes members.

(c) The family is eligible for the Klamath Tribes TANF program or would be eligible for the Klamath Tribes TANF program if not for the failure of the family to cooperate with program requirements.

(9) A family is ineligible for TANF program benefits if all of the following subsections apply to the family:

(a) A parent, caretaker relative, or child is a member of the Siletz Tribe (Confederated Tribes of Siletz Indians of Oregon) and lives in one of

the eleven service area counties: Benton, Clackamas, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, Washington, or Yamhill counties.

(b) The family includes members who are living in the same household and at least one of the following paragraphs applies:

(A) A two-parent family with one enrolled Siletz tribal member with a shared dependent.

(B) A single-parent family with one enrolled Siletz tribal member.

(C) A non-needy caretaker relative or essential person with one enrolled Siletz tribal member who is a minor.

(D) A pregnant enrolled Siletz tribal member in her eighth month of pregnancy.

(c) The family is eligible for the Siletz Tribes TANF program or would be eligible for the Siletz Tribes TANF program if not for the failure of the family to cooperate with Siletz TANF program requirements.

(10) If a parent or caretaker relative covered by section (8) or (9) of this rule fails to follow through with a Department referral to the Klamath or Siletz Tribal TANF program, the entire filing group is ineligible for TANF program benefits.

Stat. Auth.: ORS 411.060, 411.070, 411.400, 411.404, 412.006, 412.016, 412.049 & 412.124
Stats. Implemented: ORS 411.060, 411.070, 411.400, 411.404, 412.006, 412.016, 412.049, 412.064, 412.124 & 2011 OL 604 & 2012 OL 107
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 9-1991, f. 3-29-91, cert. ef. 4-1-91; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 26-1996, f. 6-27-96, cert. ef. 7-1-96; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 19-1997, f. & cert. ef. 10-1-97; AFS 25-1997(Temp), f. 12-31-97, cert. ef. 1-1-98 thru 4-30-98; AFS 8-1998, f. 4-28-98, cert. ef. 5-1-98; AFS 17-1998, f. & cert. ef. 10-1-98; AFS 26-1998(Temp), f. 12-30-98, cert. ef. 1-1-99 thru 3-31-99; AFS 2-1999, f. 3-26-99, cert. ef. 4-1-99; AFS 15-1999, f. 11-30-99, cert. ef. 12-1-99; AFS 34-2000, f. 12-22-00, cert. ef. 1-1-01; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 11-2007(Temp), f. & cert. ef. 10-1-07 thru 3-29-08; SSP 5-2008, f. 2-29-08, cert. ef. 3-1-08; SSP 8-2009(Temp), f. 4-20-09, cert. ef. 5-1-09 thru 10-28-09; SSP 19-2009(Temp), f. 7-29-09, cert. ef. 8-1-09 thru 10-28-09; SSP 33-2009, f. & cert. ef. 10-29-09; SSP 18-2011(Temp), f. & cert. ef. 7-1-11 thru 12-28-11; SSP 25-2011, f. 9-30-11, cert. ef. 10-1-11; SSP 17-2012(Temp), f. & cert. ef. 5-1-12 thru 10-28-12; SSP 30-2012, f. 9-28-12, cert. ef. 10-1-12; SSP 13-2013, f. & cert. ef. 7-1-13

461-135-0400
Specific Requirements; ERDC

(1) The Department makes payments for child care, including care covered by the ERDC program, subject to the provisions of division 165 of this chapter of rules.

(2) To be eligible for ERDC, a filing group (see OAR 461-110-0350) must meet the requirements of all of the following subsections:

(a) At least one caretaker (see OAR 461-001-0000) must receive income from employment (other than self-employment, see OAR 461-145-0910), including employment through a work study program.

(b) The filing group must include a child who needs child care.

(c) The filing group must have an allowable child care need as described in OAR 461 160 0040. If there are two adults required to be in the filing group, and one of the adults is unemployed or self-employed, the unemployed or self-employed adult is considered available to provide child care, making the filing group ineligible, except in the following situations:

(A) The unemployed adult is physically or mentally unable to provide adequate child care. This must be verified (see OAR 461-125-0830).

(B) The unemployed adult is unavailable to provide child care while participating in the requirements of a case plan (see OAR 461-001-0025) other than requirements associated with post-secondary education.

(d) The filing group must use a child care provider who meets the requirements in OAR 461-165-0160 and 461-165-0180.

(e) The child needing child care must meet the citizenship or alien status requirements of OAR 461-120-0110.

(3) A filing group is not eligible for a child care payment for more than six calendar months if the filing group is unwilling to obtain a Certificate of Immunization Status for the child.

(4) The child care must be necessary to enable the caretaker to remain employed (other than self-employed).

(5) A filing group is not eligible for child care when the caretaker or parent in the filing group receives a grant for child care from the Oregon Student Assistance Commission for any month the grant is intended to cover, regardless of when the grant is received.

Stat. Auth.: ORS 409.050, 411.060, 411.070
Stats. Implemented: ORS 409.010, 409.610, 411.010, 411.060, 411.070, 411.122, 411.141, 418.485 & 2009 OL ch. 827
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 12-1990, f. 3-30-90, cert. ef. 4-1-90; AFS 2-1992, f. 1-30-92, cert. ef. 2-1-92; AFS 20-1992, f. 7-31-92, cert. ef. 8-1-92; AFS 12-1993, f. & cert. ef. 7-1-93; AFS 13-1994, f. & cert. ef. 7-1-94; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 19-1997, f. & cert. ef. 10-1-97; AFS 17-1998, f. & cert. ef. 10-1-98; AFS 9-1999, f. & cert. ef. 7-1-99; AFS 15-1999, f. 11-30-99, cert. ef. 12-1-99; AFS 6-2001, f. 3-30-01, cert. ef. 4-1-01; AFS 27-2001, f. 12-21-01, cert. ef. 1-1-02; SSP 7-2003, f. & cert. ef. 4-1-03; SSP 35-2003(Temp), f. 12-31-03 cert. ef. 1-1-04 thru 3-31-04; SSP 8-2004, f. & cert. ef. 4-1-04; SSP 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 7-2005, f. & cert. ef. 7-1-05; SSP 6-2006, f. 3-31-06, cert. ef. 4-1-06; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 4-2009(Temp), f. 3-11-09, cert. ef. 4-1-09 thru 9-28-09; SSP 6-2009(Temp), f. & cert. ef. 4-1-09 thru 9-28-09; SSP 27-2009, f. & cert. ef. 9-29-09; SSP 18-2010, f. & cert. ef. 7-1-10; SSP 34-2010(Temp), f. & cert. ef. 10-1-10 thru 3-30-11; SSP 41-2010, f. 12-30-10, cert. ef. 1-1-11; SSP 7-2011(Temp), f. & cert. ef. 2-16-11 thru 8-15-11; SSP 9-2011(Temp), f. & cert. ef. 3-22-11 thru 8-15-11; SSP 17-2011, f. & cert. ef. 7-1-11; SSP 39-2012(Temp), f. 12-28-12, cert. ef. 1-1-13 thru 6-30-13; SSP 13-2013, f. & cert. ef. 7-1-13

461-135-0900
Specific Requirements; REF, REFM

(1) In addition to the eligibility requirements in other rules in Chapter 461 of the Oregon Administrative Rules, an individual must meet all of the requirements in this rule to be eligible for the REF and REFM programs.

(2) An individual must meet the alien status requirements of OAR 461-120-0125, except a child (see OAR 461-001-0000) born in the United States to an REF or REFM program client meets the alien status requirements for the REF and REFM programs as long as each parent (see OAR 461-001-0000) in the household group (see OAR 461-110-0210) meets the alien status requirements of OAR 461-120-0125.

(3) An individual is not eligible to receive REF and REFM program benefits if the individual is a full-time student of higher education, unless such education is part of a cash assistance case plan. Any education or training allowable under an approved case plan must be less than one year in length. For the purposes of this rule, "higher education" means education that meets the requirements of one of the following subsections:

(a) Public and private universities and colleges and community colleges that offer degree programs regardless of whether a high school diploma is required for the program. However, GED, ABE, ESL, and high school equivalency programs at these institutions are not considered higher education.

(b) Vocational, technical, business, and trade schools that normally require a high school diploma or equivalency certificate for enrollment in the curriculum or in a particular program at the institution. However, programs at those institutions that do not require the diploma or certificate are not considered higher education.

(4) Eligibility for REF and REFM program benefits is limited to the first eight months in the United States:

(a) For an individual who meets the alien status requirements of OAR 461-120-0125(8)(a), (c), (d), or (e), the month that the individual enters the U.S. counts as the first month.

(b) For an individual who meets the alien status requirements of OAR 461-120-0125(8)(b), (f), or (g), the month that the individual was granted the individual's status counts as the first month.

(c) For an individual who meets the alien status requirements of OAR 461-120-0125(8)(h):

(A) If the individual enters the U.S. with the special immigrant status, the month that the individual enters the U.S. counts as the first month.

(B) If the individual is granted special immigrant status after they have already entered the U.S., then the month in which the special immigrant status was granted counts as the first month.

(d) Months in the United States are counted as whole months. There is no prorating of months, except as described in OAR 461-193-0320.

(5) For an individual who meets the requirements of section (4) of this rule:

(a) When the individual resides in Clackamas, Multnomah, or Washington counties:

(A) The individual is not eligible to receive REF, TANF, or TANF-related employment services through the Department. To receive benefits, the individual is required to participate in the Refugee Case Service Project (RCSP) program. This individual is referred to their local resettlement agency to be enrolled in the RCSP program and receives all other Department services through the individual's local Department office.

(B) An individual who no longer meets the requirements of section (4) of this rule is no longer eligible to receive cash or case management services through the RCSP program. If this individual has been in the United States for 12 months or less, the individual is referred to the New Arrival Employment Services (NAES) program contractor for employment services.

(b) When the individual resides in counties other than Clackamas, Multnomah, and Washington, the RCSP program is not available. The individual is served at the individual's local Department office.

(6) Eligibility for any other program that provides OHP Plus benefits must be determined prior to determining eligibility for the REFM program.

(7) Eligibility for the TANF program must be determined prior to the REF program.

(8) An REF program client may not participate in the Pre-TANF program.

Stat. Auth.: ORS 409.050, 411.060 & 412.049

Stats. Implemented: ORS 409.010, 411.060 & 412.049
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 12-1990, f. 3-30-90, cert. ef. 4-1-90; AFS 20-1990, f. 8-17-90, cert. ef. 9-1-90; AFS 19-1991(Temp), f. & cert. ef. 10-1-91; AFS 4-1992, f. 2-28-92, cert. ef. 3-1-92; AFS 1-1993, f. & cert. ef. 2-1-93; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 40-1995, f. 12-26-95, cert. ef. 1-1-96; AFS 33-1996(Temp), f. 9-26-96, cert. ef. 10-1-96; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 19-1997, f. & cert. ef. 10-1-97; AFS 17-1998, f. & cert. ef. 10-1-98; AFS 15-1999, f. 11-30-99, cert. ef. 12-1-99; AFS 25-2000, f. 9-29-00, cert. ef. 10-1-00; AFS 22-2002, f. 12-31-02, cert. ef. 1-1-03; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 3-2008(Temp), f. & cert. ef. 1-30-08 thru 7-28-08; SSP 4-2008(Temp), f. & cert. ef. 2-22-08 thru 7-28-08; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 9-2009(Temp), f. & cert. ef. 5-1-09 thru 10-28-09; SSP 28-2009, f. & cert. ef. 10-1-09; SSP 13-2010(Temp), f. & cert. ef. 5-17-10 thru 11-13-10; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 13-2013, f. & cert. ef. 7-1-13

461-145-0250
Income-Producing Property

(1) Income from income producing property (see OAR 461-001-0000) is counted as follows:

(a) If a member of the financial group (see OAR 461-110-0530) actively manages the property 20 hours or more per week, the income is treated in the same manner as self-employment income (see OAR 461-145-0910, 461-145-0920, and 461-145-0930).

(b) If a member of the financial group does not actively manage the property 20 hours or more per week, the income is counted as unearned income with exclusions allowed only in accordance with OAR 461-145-0920. In the SNAP program, if the financial group owns more than one property, the exclusions for one property may not be used to offset income from a different property.

(2) The equity value (see OAR 461-001-0000) of income-producing property is treated as follows:

(a) In the EA, ERDC, and OHP programs, it is excluded.

(b) In the SNAP program, it is counted as a resource except to the extent described in each of the following situations:

(A) If the property produces an annual countable income similar to other properties in the community with comparable market value, the equity value of the property is excluded.

(B) The property is excluded under OAR 461-145-0600.

(C) The equity value of income-producing livestock, poultry, and other animals is excluded.

(D) If selling the resource would produce a net gain to the financial group of less than $1,500, the equity value is excluded.

(c) In the GA, GAM, OSIP, OSIPM, and QMB programs, it is counted as a resource, except:

(A) If the property produces an annual countable income of at least six percent of its equity value, the value of the property is excluded up to a maximum of $6,000.

(B) The total equity value is excluded (regardless of value or rate of return) if the requirements of all the following subparagraphs are met:

(i) The property is used in the trade or business of a member of the financial group, as evidenced by two or more of the following:

(I) The good faith intention of making a profit.

(II) Its use is part of a regular occupation for a member of the financial group.

(III) Holding out to others as being engaged in the selling of goods or services.

(IV) Continuity of operations, repetition of transactions, or regularity of activities.

(V) A business tax return, including forms such as Profit or Loss from Business or Profession (Schedule C), Computation of Social Security Self-Employment (Schedule SE), Farm Income and Expenses (Schedule F), Depreciation and Amortization (Form 4562), or U.S. Partnership Return of Income (Form 1065).

(ii) The property is in current use or, if not in use for reasons beyond the control of the financial group, there must be a reasonable expectation that the required use will resume.

(iii) The property is essential to the client's self-support.

(d) In the MAA, MAF, REF, REFM, SAC, and TANF programs, it is counted as a resource, except that in the MAA and TANF programs, it is excluded for a self-employed client participating in the microenterprise component of the JOBS program.

Stat. Auth.: ORS 411.060, 411.400, 411.816, 412.049
Stats. Implemented: ORS 411.060, 411.400, 411.700, 411.816, 412.049
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 20-1990, f. 8-17-90, cert. ef. 9-1-90; AFS 20-1992, f. 7-31-92, cert. ef. 8-1-92; AFS 12-1993, f. & cert. ef. 7-1-93; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 19-1994, f. & cert. ef. 9-1-94; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 10-2000, f. 3-31-00, cert. ef. 4-1-00; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; SSP 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 13-2013, f. & cert. ef. 7-1-13

461-150-0060
Prospective or Retrospective Eligibility and Budgeting; ERDC, MAA, MAF, REF, REFM, SNAP, TANF

In the ERDC, MAA, MAF, REF, REFM, SNAP, and TANF programs, the Department determines how and when to use prospective or retrospective eligibility (see OAR 461-001-0000) and budgeting (see OAR 461-001-0000) as follows:

(1) For the initial month (see OAR 461-001-0000):

(a) In the ERDC program, income is budgeted so the anticipated amount is the same for each month, including the initial month.

(b) For an MAA and MAF case, or a SNAP case in CRS, the Department uses actual income (see subsection (h) of this section) in the initial month.

(c) For a SNAP program case in SRS, actual income is used in the initial month if that income is not reflective of ongoing monthly income due to a new or terminated source or a significant change in ongoing income. All other income is processed under section (3) of this rule.

(d) In the REF and TANF programs, actual income is used in the initial month except when actual income does not reflect ongoing monthly income. All other income is processed under section (2) of this rule.

(e) In the REFM program:

(A) When a client has moved to Oregon from the client's original resettlement state, see OAR 461-135-0010.

(B) For a client not assumed eligible under paragraph (A) of this subsection and OAR 461-135-0010, the Department uses only the initial month for eligibility and budgeting.

(f) The Department uses prospective eligibility and budgeting under OAR 461-150-0020 for cases not covered under subsections (a) to (e) of this section, including for a client who leaves a filing group because of domestic violence (see OAR 461-001-0000) and enters a domestic violence shelter (see OAR 461-001-0000) or safe home (see OAR 461-001-0000).

(g) No supplement is issued based on incorrectly anticipated information.

(h) "Actual income" is the income already received in the initial month plus all the income that reasonably may be expected to be received within the initial month.

(2) Income is budgeted so that the anticipated amount is the same for each month. The type of income is determined and calculated as follows:

(a) Income that must be annualized is calculated under OAR 461-150-0090 to arrive at a monthly figure.

(b) Educational income (see OAR 461-145-0150) is assigned to the months it is intended to cover, regardless of when it is received. The income is prorated over these months.

(c) Ongoing stable income (see OAR 461-001-0000) is anticipated under OAR 461-150-0070.

(d) Ongoing variable income (see OAR 461-001-0000) is anticipated under OAR 461-150-0080.

(e) Periodic income (see OAR 461-001-0000) is anticipated under OAR 461-140-0100 and 461-140-0110.

(f) Lump-sum income (see OAR 461-001-0000) is anticipated under OAR 461-140-0100, 461-140-0200, and 461-140-0123.

(g) In the ERDC program, for temporary income and other situations when the child care need will last two consecutive months or less, the income is anticipated to be received in the months of child care need and calculated under OAR 461-150-0080.

(3) For an ongoing month (see OAR 461-001-0000):

(a) For a benefit group (see OAR 461-110-0750), the Department uses prospective eligibility and budgeting. The type of income is determined and calculated under section (2) of this rule.

(b) If the budgeting method changes from prospective to retrospective, the Department treats income from a terminated source that was counted prospectively as follows:

(A) If the actual amount received was less than or equal to the anticipated amount, the income is excluded.

(B) If the actual amount received was greater than the anticipated amount, the Department counts the difference between actual and anticipated amounts.

(4) When an individual is added to an ongoing filing and benefit group, prospective budgeting is used to determine eligibility.

(5) In the ERDC and SNAP programs, income reported on the Interim Change Report form under OAR 461-170-0011 and 461-170-0102 is used to determine eligibility and benefit level. Income for the fifth month of the SNAP program certification period (see OAR 461-001-0000) is used to determine the income for the seventh and following months in the certification period if the client anticipates it will remain the same throughout the

period. If the client anticipates the income will change, the client and the Department jointly estimate the income for the remaining months of the certification period. For a client who had self-employment income annualized, no change is made unless there is a substantial change in the revenue of the business.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.816 & 412.049
Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.816 & 412.049
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 20-1990, f. 8-17-90, cert. ef. 9-1-90; AFS 30-1990, f. 12-31-90, cert. ef. 1-1-91; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 6-1994, f. & cert. ef. 4-1-94; AFS 13-1994, f. & cert. ef. 7-1-94; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 3-1997, f. 3-31-97, cert. ef. 4-1-97; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 3-2000, f. 1-31-00, cert. ef. 2-1-00; AFS 6-2001, f. 3-30-01, cert. ef. 4-1-01; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 13-2009, f. & cert. ef. 7-1-09; SSP 5-2010, f. & cert. ef. 4-1-10; SSP 13-2013, f. & cert. ef. 7-1-13

461-155-0150
Child Care Eligibility Standard, Payment Rates, and Copayments

The following provisions apply to child care in the ERDC, JOBS, JOBS Plus, and TANF programs:

(1) The following definitions apply to the rules governing child care rates:

(a) Infant: For all providers other than licensed (registered or certified) care, a child aged newborn to 1 year. For licensed care, an infant is a child aged newborn to 18 months.

(b) Toddler: For all providers other than licensed (registered or certified) care, a child aged 1 year to 3 years. For licensed care, a toddler is a child aged 18 months to 3 years.

(c) Preschool: A child aged 3 years to 6 years.

(d) School: A child aged 6 years or older.

(e) Special Needs: A child who meets the age requirement of the program (ERDC or TANF) and who requires a level of care over and above the norm for his or her age due to a physical, behavioral or mental disability. The need for a higher level of care must be determined by the provider and the disability must be verified by one of the following:

(A) A physician, nurse practitioner, clinical social worker, or any additional sources in OAR 461-125-0830.

(B) Eligibility for Early Intervention and Early Childhood Special Education Programs, or school-age Special Education Programs.

(C) Eligibility for SSI.

(2) The following definitions apply to the types of care specified in the child care rate charts in subsections (4)(a) through (4)(c) of this rule:

(a) The Standard Family Rate applies to child care provided in the provider's own home or in the home of the child when the provider does not qualify for the enhanced rate allowed by subsection (b) of this section.

(b) The Enhanced Family Rate applies to child care provided in the provider's own home or in the home of the child when the provider meets the training requirements of the Oregon Registry, established by the Oregon Center for Career Development in Childhood Care and Education.

(c) The Registered Family Rate applies to child care provided in the provider's own home when the provider meets criteria established by the Child Care Division.

(d) The Certified Family Rate applies to child care provided in a residential dwelling that is certified by the Child Care Division as a Certified Family Home. To earn this designation, the facility must be inspected, and both provider and facility are required to meet certain standards not required of a registered family provider.

(e) The Standard Center Rate applies to child care provided in a facility that is not located in a residential dwelling and is exempt from Child Care Division Certification rules (see OAR 414-300-0000).

(f) The Enhanced Center Rate applies to child care provided in an exempt center whose staff meet the training requirements of the Oregon Registry established by the Oregon Center for Career Development in Childhood Care and Education. Eligibility to receive the enhanced center rate for care provided in an exempt center is subject to the following requirements:

(A) A minimum of one staff member for every 20 children in care must meet the Oregon Registry training requirements noted in paragraph (2)(b) of this rule.

(B) New staff must meet the Oregon Registry training requirements within 90 days of hire, if necessary to maintain the trained staff-to-children ratio described in paragraph (A) of this subsection.

(C) There must be at least one person present where care is provided who has a current certificate in infant and child CPR and a current American Red Cross First Aid card or an equivalent.

(g) An enhanced rate will become effective not later than the second month following the month in which the Department receives verification that the provider has met the requirements of subsection (2)(b), (f), or (g) of this rule.

(h) The Certified Center Rate applies to child care provided in a center that is certified by the Child Care Division.

(3) The following provisions apply to child care payments:

(a) Providers not eligible for the enhanced or licensed rate will be paid at an hourly rate for children in care less than 158 hours per month subject to the maximum full-time monthly rate.

(b) Providers eligible for the enhanced or licensed rate will be paid at an hourly rate for children in care less than 136 hours a month, unless the provider customarily bills all families at a part-time monthly rate (subject to the maximum full-time monthly rate) and is designated as the primary provider for the case.

(c) At their request, providers eligible for the enhanced or licensed rate may be paid at the part-time monthly rate if they provide 63 or more hours of care in the month, customarily bill all families at a part-time monthly rate, and are designated as the primary provider for the case.

(d) Unless required by the circumstances of the client or child, the Department will not pay for care at a part-time monthly or a monthly rate to more than one provider for the same child for the same month.

(e) The Department will pay at the hourly rate for less than 63 hours of care in the month subject to the maximum full-time monthly rate.

(f) The Department will pay for up to five days each month the child is absent if:

(A) The child was scheduled to be in care and the provider bills for the amount of time the child was scheduled to be in care; and

(B) It is the provider's policy to bill all families for absent days.

(g) The Department will not pay for more than five consecutive days of scheduled care for which the child is absent.

(4) The following are the child care rates, the rates are based on the type of provider, the location of the provider (shown by zip code), the age of the child, and the type of billing used (hourly or monthly):

(a) [Table not included. See ED. NOTE.]

(b) [Table not included. See ED. NOTE.]

(c) [Table not included. See ED. NOTE.]

(5) Except to the extent provided otherwise in section (12) of this rule, this section establishes the ERDC eligibility standard and the client's copayment (copay).

(a) The ERDC eligibility standard is met for need groups (see OAR 461-110-0630) of eight or less if monthly countable income (see OAR 461-001-0000) for the need group is less than 185 percent of the federal poverty level (FPL), as described in OAR 461-155-0180(6). The eligibility standard for a need group size of eight applies to any need group larger than eight.

(b) The minimum monthly ERDC copay is $25.

(c) For filing groups (see OAR 461-110-0310) whose countable income is at or below 50 percent of the 2007 FPL, the copay is $25 or 1.5 percent of the filing group's monthly countable income, whichever is greater.

(d) For filing groups whose countable income is over 50 percent of the 2007 FPL, the copay amount is determined with the following percentage of monthly income:

(A) Determine filing group's countable income as a percent of FPL (rounding to the nearest hundredth of the percentage), subtract 50, and multiply this difference by 0.12.

(B) Add 1.5 to the amount in paragraph (A) of this subsection. This sum is the percentage of monthly income to determine the copay amount.

(e) The 2007 federal poverty level used to determine copay amounts under subsections (c) and (d) of this section is set at the following amounts: [Table not included. See ED. NOTE.]

(6) Subject to the provisions in section (9) of this rule, the monthly limit for each child's child care payments is the lesser of the amount charged by the provider or providers and the following amounts:

(a) The monthly rate provided in section (4) of this rule.

(b) The product of the hours of care, limited by section (8) of this rule, multiplied by the hourly rate provided in section (4) of this rule.

(7) The limit in any month for child care payments on behalf of a child whose caretaker is away from the child's home for more than 30 days because the caretaker is a member of a reserve or National Guard unit that is called up for active duty is the lesser of the following:

(a) The amount billed by the provider or providers.

(b) The monthly rate established in this rule for 215 hours of care.

(8) The number of payable billed hours of care for a child is limited as follows:

(a) In the ERDC and TANF programs, the total payable hours of care in a month may not exceed:

(A) 125 percent of the number of hours necessary for the client to perform the duties of his or her job, or to participate in activities included in a case plan (see OAR 461-001-0025) including, for clients in the JOBS Plus program, the time the client searches for unsubsidized employment and for which the employer pays the client; or

(B) The monthly rate established in section (4) of this rule multiplied by a factor of not more than 1.5, determined by dividing the number of hours billed by 215, when the client meets the criteria for extra hours under section (10) of this rule.

(b) In the ERDC program, for a client who earns less than the Oregon minimum wage, the total may not exceed 125 percent of the anticipated earnings divided by the state minimum wage not to exceed 172 hours (which is full time). The limitation of this subsection is waived for the first three months of the client's employment.

(c) In the TANF program, for a client who earns less than the Oregon minimum wage or is self-employed, the total may not exceed 125 percent of the anticipated earnings divided by the state minimum wage not to exceed 172 hours (which is full time). The limitation of this subsection is waived for the first three months of the client's employment.

(9) The limit in any month for child care payments on behalf of a child whose caretaker has special circumstances, defined in section (10) of this rule, is the lesser of one of the following:

(a) The amount billed by the provider or providers; or

(b) The monthly rate established in section (4) of this rule multiplied by a factor, of not more than 1.5, determined by dividing the number of hours billed by 215.

(10) The limit allowed by section (9) of this rule is authorized once the Department has determined the client has special circumstances. For the purposes of this section, a client has special circumstances when it is necessary for the client to obtain child care in excess of 215 hours in a month to perform the requirements of his or her employment or training. This is limited to the following situations:

(a) The commute time to and from work exceeds two hours per day.

(b) The caretaker works an overnight shift and care is necessary for both work hours and sleep hours.

(c) The caretaker works a split shift and it is not feasible to care for the child between shifts.

(d) The caretaker consistently works more than 40 hours per week.

(e) Weekend work or other nonstandard work hours require care by more than one provider, and the total allowable hours billed by both providers exceeds the maximum limit.

(f) The caretaker needs child care for both full-time work and participation in Department assigned activities.

(11) The payment available for care of a child who meets the special needs criteria described in subsection (1)(e) of this rule is increased in accordance with OAR 461-155-0151 if the requirements of both of the following subsections are met:

(a) The child requires significantly more direct supervision by the child care provider than normal for a child of the same age; and

(b) The child is enrolled in a local school district Early Intervention or Early Childhood Special Education program or school-age Special Education Program. The enrollment required by this subsection is waived if determined inappropriate by a physician, nurse practitioner, licensed or certified psychologist, clinical social worker, or school district official.

(12) Starting May 1, 2012:

(a) The minimum monthly ERDC copay is $27.

(b) Except as stated in subsection (a) of this section, the Department adds 10 percent to the monthly client co-payment amount set under section (5) of this rule.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409.050, 411.060, 411.070, 412.006 & 412.049

Stats. Implemented: ORS 409.010, 409.610, 411.060, 411.070, 412.006 & 412.049

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 12-1990, f. 3-30-90, cert. ef. 4-1-90; AFS 16-1990, f. 6-29-90, cert. ef. 7-1-90; AFS 30-1990, f. 12-31-90, cert. ef. 1-1-91; AFS 19-1991(Temp), f. & cert. ef. 10-1-91; AFS 4-1992, f. 2-28-92, cert. ef. 3-1-92; AFS 14-1992, f. & cert. ef. 6-1-92; AFS 20-1992, f. 7-31-92, cert. ef. 8-1-92; AFS 10-1993, f. & cert. ef. 6-1-93; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 9-1994, f. 4-29-94, cert. ef. 5-1-94; AFS 13-1994, f. & cert. ef. 7-1-94; AFS 19-1994, f. & cert. ef. 9-1-94; AFS 23-1994, f. 9-29-94, cert. ef. 10-1-94; AFS 23-1995, f. 4-20-95, cert. ef. 10-1-95; AFS 41-1995, f. 12-26-95, cert. ef. 1-1-96; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 19-1997, f. & cert. ef. 10-1-97; AFS 10-1998, f. 6-29-98, cert. ef. 7-1-98; AFS 14-1999, f. & cert. ef. 11-1-99; AFS 16-1999, f. 12-29-99, cert. ef. 1-1-00; AFS 4-2000(Temp), f. 2-29-00, cert. ef. 3-1-00 thru 8-25-00; AFS 10-2000, f. 3-31-00, cert. ef. 4-1-00; AFS 17-2000, f. 6-28-00, cert. ef. 7-1-00; AFS 34-2000, f. 12-22-00, cert. ef. 1-1-01; AFS 22-2001, f. & cert. ef. 10-1-01; AFS 27-2001, f. 12-21-01, cert. ef. 1-1-02; AFS 10-2002, f. & cert. ef. 7-1-02; AFS 13-2002, f. & cert. ef. 10-1-02; AFS 23-2002(Temp), f. 12-31-02, cert. ef. 1-1-03 thru 6-30-03; SSP 2-2003(Temp); f. & cert. ef. 2-7-03 thru 6-30-03; SSP 16-2003, f. & cert. ef. 7-1-03; SSP 23-2003, f. & cert. ef. 10-1-03; SSP 24-2003(Temp), f. & cert. ef. 10-1-03 thru 12-31-03; SSP 35-2003(Temp), f. 12-31-03 cert. ef. 1-1-04 thru 3-31-04; SSP 33-2003, f. 12-31-03, cert. ef. 1-4-04; SSP 35-2003(Temp), f. 12-31-03 cert. ef. 1-1-04 thru 3-31-04; SSP 8-2004, f. & cert. ef. 4-1-04; SSP 14-2005, f. 9-30-05, cert. ef. 10-1-05; SSP 19-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 7-2006(Temp), f. 3-31-06, cert. ef. 4-1-06 thru 9-28-06; SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; SSP 11-2007(Temp), f. & cert. ef. 10-1-07 thru 3-29-08; SSP 5-2008, f. 2-29-08, cert. ef. 3-1-08; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 4-2009(Temp), f. 3-11-09, cert. ef. 4-1-09 thru 9-28-09; SSP 27-2009, f. & cert. ef. 9-29-09; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 17-2011, f. & cert. ef. 7-1-11; SSP 35-2011, f. 12-27-11, cert. ef. 1-1-12; SSP 13-2012(Temp), f. & cert. ef. 4-10-12 thru 10-7-10; SSP 30-2012, f. 9-28-12, cert. ef. 10-1-12; SSP 39-2012(Temp), f. 12-28-12, cert. ef. 1-1-13 thru 6-30-13; SSP 13-2013, f. & cert. ef. 7-1-13

461-155-0180

Poverty Related Income Standards; Not OSIP, OSIPM, QMB

(1) A Department program may cite this rule if the program uses a monthly income standard based on the federal poverty level.

(2) A monthly income standard set at 100 percent of the 2013 federal poverty level is set at the following amounts: [Table not included. See ED. NOTE.]

(3) A monthly income standard set at 133 percent of the 2013 federal poverty level is set at the following amounts: [Table not included. See ED. NOTE.]

(4) A monthly income standard set at 150 percent of the 2013 federal poverty level is set at the following amounts: [Table not included. See ED. NOTE.]

(5) A monthly income standard set at 163 percent of the 2013 federal poverty level is set at the following amounts: [Table not included. See ED. NOTE.]

(6) A monthly income standard set at 185 percent of the 2013 federal poverty level is set at the following amounts: [Table not included. See ED. NOTE.]

(7) A monthly income standard set at 200 percent of the 2013 federal poverty level is set at the following amounts: [Table not included. See ED. NOTE.]

(8) A monthly income standard set at 201 percent of the 2013 federal poverty level is set at the following amounts: [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.816 & 412.049

Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.816 & 412.049

Hist.: SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; SSP 1-2007, f. & cert. ef. 1-24-07; SSP 1-2008(Temp), f. & cert. ef. 1-24-08 thru 6-30-08; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 1-2009, f. & cert. ef. 1-27-09; SSP 29-2009(Temp), f. & cert. ef. 10-1-09 thru 3-30-10; SSP 4-2010, f. & cert. ef. 3-31-10; SSP 25-2010(Temp), f. & cert. ef. 8-16-10 thru 2-12-11; SSP 41-2010, f. 12-30-10, cert. ef. 1-1-11; SSP 1-2011(Temp), f. & cert. ef. 1-20-11 thru 7-19-11; SSP 17-2011, f. & cert. ef. 7-1-11; SSP 2-2012, f. & cert. ef. 1-25-12; SSP 3-2013, f. & cert. ef. 1-30-13; SSP 5-2013(Temp), f. & cert. ef. 2-1-13 thru 7-31-13; SSP 13-2013, f. & cert. ef. 7-1-13

461-155-0710

Special Need; Diversion and Transition Services; OSIP and OSIPM

In the OSIP and OSIPM programs:

(1) The Department may authorize one-time payments for expenses that the Department has determined are necessary to divert or transition individuals from nursing facility services. Payments are allowed for clients who are receiving or eligible to receive community based care (see OAR 461-001-0000).

(2) Payments will be authorized at the lowest possible cost.

(3) To be eligible for payment, clients may not be eligible for the item through Medicare, Medicaid, or any other medical coverage.

(4) Payment for a household item is not allowed if the community based care facility is required to provide the item by contract or administrative rule.

(5) Payment is not allowed if the item or service may be provided under any other special need rule in this division (OAR 461-155-0510 to 461-155-0700).

Stat. Auth: ORS 409.050, 411.060 & 411.070

Stats. Implemented: ORS 409.010, 411.060 & 411.070

Hist.: SSP 22-2008(Temp), f. & cert. ef. 10-1-08 thru 3-30-09; SSP 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 13-2013, f. & cert. ef. 7-1-13

461-160-0040

Dependent Care Costs; Deduction and Coverage

(1) In the MAF program, the cost of child care for a dependent child (see OAR 461-001-0000) may be deducted from the income of a client in accordance with the following:

(a) The dependent child must live with the filing group;

(b) The provider of child care may not be in the filing group;

(c) The provider of child care may not be the parent (see OAR 461-001-0000) of the dependent child; and

(d) The amount of the deduction is determined as set out in OAR 461-160-0190.

(2) In the SNAP program, dependent care is deductible (see OAR 461-160-0430) when all of the following are true:

(a) The dependent is a member of the filing group and is in the care, control, and custody of an individual in the group.

(b) The dependent care provider:

(A) Is not in the filing group; and

(B) Is not the parent of the dependent.

(c) The dependent care is necessary because the client is working, commuting, on a meal break, in training, participating in pre-employment education, or participating in an OFSET case plan (see OAR 461-001-0020).

(3) In the ERDC, REF, and TANF programs, the cost of dependent child care may be paid for by the Department (is covered) only if dependent child care is necessary for the working client to perform his or her job duties. For a client working under a JOBS Plus agreement, child care is covered during the time the client is engaged in work or in job search if the employer pays the client during that time.

(4) In the ERDC, JOBS, REF, and TANF programs, the cost of dependent child care is not covered by the Department when free care is available, such as during school hours for school-age children.

(5) Child care is not covered in the ERDC, REF, and TANF programs if the nature of the work of the caretaker does not make it necessary for a person other than the caretaker (see OAR 461-001-0000) to provide the care. Child care is not covered during a period of time when the caretaker:

(a) Works at home and the nature of the work allows the caretaker to provide the care without significantly affecting the work;

(b) Provides child care in a residence; or

(c) Works for a provider of child care in a residence that is not certified under OAR 414-350-0000 to 414-350-0400.

(6) In the ERDC program:

(a) Child care is not covered during a period of time when the caretaker is self-employed (see OAR 461-145-0910).

(b) The cost of dependent child care may continue to be paid for, at the same benefit level, by the Department (is covered) for job search, through the end of the month following the month in which a loss of all employment for an adult in the filing group occurred if both of the following paragraphs apply.

(A) The loss of employment is reported in a timely manner.

(B) None of the following sub-paragraphs apply:

(i) The loss of employment included self-employment.

(ii) The adult was discharged or fired without good cause (see OAR 461-135-0070(3)) for misconduct, felony, or theft. "Misconduct" means willful or wantonly negligent violation of the standards of behavior which an employer has the right to expect of an employee, including an act or series of actions that amount to a willful or wantonly negligent disregard of an employer's interest.

(iii) The adult voluntarily quit in anticipation of discharge or without good cause (see OAR 461-135-0070(3)).

(7) In the JOBS and REF programs, the cost of child care may be covered while the care is necessary to enable the client to participate in a case plan (see OAR 461-190-0211).

(8) In the ERDC, JOBS, JOBS Plus, REF, and TANF programs, the cost of dependent child care may be paid for (is covered) by the Department, only if all the following are true:

(a) The dependent child:

(A) In the ERDC program, is a member of the benefit group (see OAR 461-110-0750) and is in the care, control, and custody of an individual in the group.

(B) In the JOBS, JOBS Plus, REF, and TANF programs, lives with the filing group.

(b) The provider of child care is not in the filing group.

(c) The provider of child care is not the parent of the dependent.

(9) Coverage of the cost of dependent care is subject to the requirements in Chapter 461 of the Oregon Administrative Rules, including OAR 461-120-0510(6), 461-135-0400, 461-155-0150, 461-160-0193, 461-165-0180, and 461-190-0211.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.700, 411.816, 412.049
Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.700, 411.816, 412.049
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 2-1992, f. 1-30-92, cert. ef. 2-1-92; AFS 17-1992, f. & cert. ef. 7-1-92; AFS 20-1992, f. 7-31-92, cert. ef. 8-1-92; AFS 1-1993, f. & cert. ef. 2-1-93; AFS 12-1993, f. & cert. ef. 7-1-93; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 23-1994, f. 9-29-94, cert. ef. 10-1-94; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 24-1997, f. 12-31-97, cert. ef. 1-1-98; AFS 14-1999, f. & cert. ef. 11-1-99; AFS 6-2001, f. 3-30-01, cert. ef. 4-1-01; AFS 5-2002, f. & cert. ef. 4-1-02; SSP 7-2003, f. & cert. ef. 4-1-03; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 14-2005, f. 9-30-05, cert. ef. 10-1-05; SSP 6-2006, f. 3-31-06, cert. ef. 4-1-06; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 14-2007, f. 12-31-07, cert. ef. 1-1-08; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 4-2009(Temp), f. 3-11-09, cert. ef. 4-1-09 thru 9-28-09; SSP 27-2009, f. & cert. ef. 9-29-09; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 13-2013, f. & cert. ef. 7-1-13

461-175-0222

Notice Situations — Expiration of Certification Period; ERDC, SNAP, TANF

In the ERDC, SNAP, and TANF programs:

(1) The Department must provide a household certified for one month or certified in the second month of a two-month certification period (see OAR 461-001-0000) a notice of expiration at the time of certification.

(2) In the ERDC program, each household not covered under section (1) of this rule must receive a notice of expiration prior to the last month of the certification period.

(3) In the ERDC program, the notice of expiration must contain:

(a) The date the certification period expires.

(b) A statement that to receive benefits, the client must reapply and be found eligible for a new benefit amount.

(c) The household's right to request a contested case hearing if the reapplication is denied or if the household objects to the benefit amount.

(4) In the SNAP program, each household other than those covered under section (1) of this rule must receive a notice of expiration before the first day of the last month of the certification period (established per OAR 461-115-0450), but not before the first day of the next-to-the-last month.

(5) In the SNAP program, notice of expiration under this rule is provided to the filing group (see OAR 461-110-0370) and must contain all of the following:

(a) The date the certification period expires.

(b) The date by which a household must submit an application for recertification to receive uninterrupted benefits.

(c) The consequences of failure to apply for recertification in a timely manner.

(d) The right to receive an application form upon request and to have it accepted as long as it contains a signature and a legible name and address.

(e) Information on alternative submission methods available to households that are not able to come into the certification office or do not have an authorized representative and how to exercise these options.

(f) The address of the office where the application must be filed.

(g) The household's right to request a contested case hearing if the recertification is denied or if the household objects to the benefit amount.

(h) A statement that any household consisting only of Supplemental Security Income (SSI) applicants or recipients is entitled to apply for SNAP program benefits recertification at an office of the Social Security Administration.

(i) A statement that failure to attend an interview may result in delay or denial of benefits.

(j) A statement that the household is responsible for rescheduling a missed interview and for providing required verification information.

(k) A statement that the client has no rights to continuation of benefits after the SNAP program certification period expires; and that to receive benefits, the client must reapply and be found eligible for a new benefit amount after the end of the certification period, including a client who is receiving continuation of benefits when his or her SNAP program certification period ends.

(6) In the TANF program, each household other than those covered under section (1) of this rule must be sent:

(a) Before the first day of the last month of the certification period (see OAR 461-001-0000 and 461-115-0430), but not before the first day of the next-to-the-last month, a recertification packet that contains application forms, deadlines, and information about the consequences of not reapplying on time; and

(b) A basic decision notice (see OAR 461-001-0000) about the expiration of the certification period (see OAR 461-001-0000 and 461-115-0430).

Stat. Auth: ORS 409.050, 411.060, 411.070, 411.816, 412.049
Stats. Implemented: ORS 409.010, 411.060, 411.070, 411.816, 412.049
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 20-1990, f. 8-17-90, cert. ef. 9-1-90; AFS 30-1990, f. 12-31-90, cert. ef. 1-1-91; AFS 1-2000, f. 1-13-00, cert. ef. 2-1-00; Renumbered from 461-115-0510, SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 15-2010, f. & cert. ef. 5-27-10; SSP 13-2013, f. & cert. ef. 7-1-13

461-193-0320

Effective Dates for Cash Assistance; Refugee Case Service Project

In the Refugee Case Service Project (RCSP) , eligibility for cash assistance is according to the following dates:

(1) After all initial eligibility factors for the case are completed and verified, the initial cash assistance date is set as the date of the case service intake, except as stated in section (2).

(2) When all of the following subsections are met, the effective date for cash assistance is the first day of the month in which the date of application falls:

(a) The individual is eligible to receive REF assistance.

(b) The individual's entry to the United States:

(A) And application date fall within the same month; or

(B) Was in another state while in transit to Oregon for resettlement, and the application date falls in the second month of arrival in the United States.

(c) The individual has not received refugee cash assistance in any other state.

(3) For a child born in the United States to a refugee already enrolled in RCSP as per section (1) of this rule, the initial cash assistance date is set as the date of birth.

(4) For an applicant who quit a job or refused to accept an offer of employment without good cause (see OAR 461-193-0890) within 30 consecutive calendar days immediately prior to the application, the initial cash assistance eligibility is no earlier than the 30th day from the date of the job quit or job refusal.

(5) For cases in which a disqualification has been removed due to a client's compliance with participation requirements and completion of a cooperation period of two consecutive weeks as specified in a new employment plan, the cash eligibility date is the date the client agreed to re-engage, per OAR 461-193-1230.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.116, 412.006, 412.049

Stats. Implemented: ORS 409.010, 411.060, 411.070, 411.116, 412.006, 412.049

Hist.: AFS 25-1991, f. 12-30-91, cert. ef. 1-1-92; AFS 2-1994, f. & cert. 2-1-94; AFS 37-1995, f. 11-28-95, cert. ef. 12-1-95; AFS 2-1996(Temp), f. 1-30-96, cert. ef. 2-1-96; AFS 11-1996, f. 3-27-96, cert. ef. 4-1-96; AFS 34-1996, f. 9-26-96, cert. ef. 10-1-96; AFS 5-1997, f. 4-30-97, cert. ef. 5-1-97; AFS 19-1997, f. & cert. ef. 10-1-97; AFS 8-2000(Temp), f. 3-10-00, cert. ef. 3-10-00 thru 5-1-00; AFS 14-2000, f. & cert. ef. 5-2-00; SSP 30-2012, f. 9-28-12, cert. ef. 10-1-12; SSP 13-2013, f. & cert. ef. 7-1-13

461-195-0521

Calculation of Overpayments

This rule specifies how the Department calculates an overpayment (see OAR 461-195-0501).

(1) The Department calculates an overpayment by determining the amount the client received or the payment made by the Department on behalf of the client that exceeds the amount for which the client was eligible.

(2) When a filing group, ineligible student, or authorized representative (see OAR 461-115-0090) fails to report income, the Department calculates and determines the overpayment by assigning unreported income to the applicable budget month without averaging the unreported income, except:

(a) A client's earned income reported quarterly from the Employment Department is considered received by the client in equal amounts during the months identified in the report.

(b) In the ERDC, MAA, MAF, REF, SNAP, and TANF programs, a client's actual self-employment income is annualized retrospectively to calculate the overpayment.

(3) When using prospective budgeting (see OAR division 461-150) and the actual income differs from the amount determined under OAR 461-150-0020(2), there may be a client error overpayment (see OAR 461-195-0501) only when the filing group, ineligible student, or authorized representative withheld information, failed to report a change, or provided inaccurate information. In such a case, the Department uses the actual income to determine the amount of an overpayment.

(4) When a filing group, ineligible student, or authorized representative fails to report all earned income within the reporting time frame, the earned income deduction (see OAR 461-160-0160, 461-160-0190, 461-160-0430, 461-160-0550, and 461-160-0552) is applied as follows:

(a) In the OSIP, OSIPM, QMB, and REFM programs, the Department allows the earned income deduction.

(b) In the MAA, MAF, REF, and TANF programs, the Department allows the earned income deduction when good cause (see section (5) of this rule) exists.

(c) In the SNAP program, no deduction is applied to earned income not timely reported.

(5) For the purposes of OAR 461-195-0501 to 461-195-0561, "good cause" means circumstances beyond the client's reasonable control that caused the client to be unable to report income timely and accurately.

(6) When support is retained:

(a) In the TANF program, the amount of support (other than cash medical support) the Department of Justice retains as a current reimbursement each month is added to other income to determine eligibility. When a client is not eligible for TANF program benefits, the overpayment is offset by the support the Department of Justice retains as a current reimbursement.

(b) In the medical programs, the amount of the cash medical support the Department retains each month is excluded income and not used to determine eligibility for medical program benefits. When a client has incurred a medical program overpayment, the overpayment is offset by the amount of the cash medical support the Department retains during each month of the overpayment.

(7) In the REF and TANF programs, when a client directly receives support used to determine eligibility or calculate benefits, the overpayment is:

(a) If still eligible for REF or TANF program benefits, the amount of support the client received directly; or

(b) If no longer eligible for REF or TANF program benefits, the amount of program benefits the client received.

(8) When an overpayment occurs due to the failure of an individual to reimburse the Department, when required by law to do so, for benefits or services (including cash medical support) provided for a need for which that individual is compensated by another source, the overpayment is limited to the lesser of the following:

(a) The amount of the payment from the Department;

(b) Cash medical support; or

(c) The amount by which the total of all payments exceeds the amount payable for such a need under the Department's rules.

(9) Benefits paid during a required notice period (see OAR 461-175-0050) are included in the calculation of the overpayment when:

(a) The filing group, ineligible student, or authorized representative failed to report a change within the reporting time frame under OAR 461-170-0011; and

(b) Sufficient time existed for the Department to adjust the benefits to prevent the overpayment if the filing group, ineligible student, or authorized representative had reported the change at any time within the reporting time frame.

(10) In the SNAP program:

(a) If the benefit group (see OAR 461-110-0750) was categorically eligible, there is no overpayment based on resources.

(b) For a filing group (see OAR 461-110-0370) found eligible for SNAP program benefits under OAR 461-135-0505(1)(a) to (c), and the actual income made the group ineligible for the related program, the group remains categorically eligible for SNAP program benefits as long as the eligibility requirement under OAR 461-135-0505(1)(d) is met. A benefit group of one or two individuals would be entitled to at least the minimum SNAP program benefit allotment under OAR 461-165-0060.

(c) For a filing group found eligible for SNAP program benefits only under OAR 461-135-0505(1)(d), and the actual income equals or exceeds 185 percent of the Federal Poverty Level, the filing group is no longer categorically eligible. The overpayment is the amount of SNAP program benefits incorrectly received.

(11) In the OSIP and OSIPM programs, when a client does not pay his or her share of the cost of services (see OAR 461-160-0610) or the OSIP-EPD or OSIPM-EPD program participant fee (see OAR 461-160-0800) in the month in which it is due, an overpayment is calculated as follows:

(a) All payments made by the Department on behalf of the client during the month in question are totaled, including but not limited to any payment for:

(A) Capitation;

(B) Long term care services;

(C) Medical expenses for the month in question;

(D) Medicare buy-in (when not concurrently eligible for an MSP);

(E) Medicare Part D;

(F) Mileage reimbursement;

(G) Special needs under OAR 461-155-0500 to 416-155-0710; and

(H) Waivered services, including home delivered meals and non-medical transportation.

(b) Any partial or late liability payment made by a client receiving in-home waivered services (see OAR 461-001-0030) or participant fee paid by an OSIP-EPD or OSIPM-EPD program client is subtracted from the total calculated under subsection (a) of this section. The remainder, if any, is the amount of the overpayment.

(12) When a client's liability is unreduced pending the outcome of a contested case hearing about that liability the overpayment is the difference between the liability amount determined in the final order and the amount, if any, the client has repaid.

(13) In the BCCM, CEC, CEM, EXT, MAA, MAF, OHP-CHP, OHP-OPC, OHP-OPP, OHP-OPU, OHP-OP6, OSIPM, QMB, REFM, and SAC programs if the client was not eligible for one program, but during the period in question was eligible for another program:

(a) With the same benefit level, there is no overpayment.

(b) With a lesser benefit level, the overpayment is the amount of medical program benefit payments made on behalf of the client exceeding the amount for which the client was eligible.

(14) When an overpayment is caused by administrative error (see OAR 461-195-0501), any overpayment of GA, OSIP, REF, SFPSS, or TANF program benefits is not counted as income when determining eligibility for the EXT, GAM, MAA, MAF, OSIPM, REFM, and SAC programs.

(15) Credit against an overpayment is allowed as follows:

(a) In the GA, REF, and TANF programs, a credit is allowed for a client's payment for medical services made during the period covered by the overpayment, in an amount not to exceed the Department fee schedule for the service, but credit is not allowed for an elective procedure unless the Department authorized the procedure prior to its completion.

(b) In the SNAP program, if the overpayment was caused by unreported earned income, verified child care costs are allowed as a credit to the extent the costs would have been deductible under OAR 461-160-0040 and 461-160-0430.

(c) In the SFPSS and TANF programs, if the overpayment is caused by reported earned income, a credit is allowed for the Post-TANF grant if the client meets eligibility under OAR 461-135-1250 and the client has received less than 12 months of Post-TANF program benefits.

(d) In all programs, for an underpayment of benefits.

(16) In the SNAP program, in compliance with the American Recovery and Reinvestment Act of 2009, effective April 1, 2009 through September 30, 2009, the amount between the normal Thrifty Food Plan (TFP) benefit amount under this section and the increased TFP benefit amount under OAR 461-155-0190 is not counted in the overpayment amount unless the filing group was ineligible for SNAP program benefits. [Table not included. See ED. NOTE]

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 411.660, 411.706, 411.816, 412.014, 412.049, 412.124, 414.231

Stats. Implemented: ORS 409.010, 411.060, 411.070, 411.404, 411.620, 411.630, 411.635, 411.640, 411.660, 411.690, 411.706, 411.816, 412.014, 412.049, 412.124, 414.231, 416.350

Hist.: AFS 3-2000, f. 1-31-00, cert. ef. 2-1-00; AFS 25-2000, f. 9-29-00, cert. ef. 10-1-00; AFS 6-2001, f. 3-30-01, cert. ef. 4-1-01; AFS 27-2001, f. 12-21-01, cert. ef. 1-1-02; AFS 22-2002, f. 12-31-02, cert ef. 1-1-03; SSP 23-2003, f. & cert. ef. 10-1-03; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; SSP 20-2003, f. & cert. ef. 8-15-03; SSP 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 14-2007, f. 12-31-07, cert. ef. 1-1-08; SSP 8-2008, f. & cert. ef. 4-1-08; SSP 6-2009(Temp), f. & cert. ef. 4-1-09 thru 9-28-09; SSP 13-2009, f. & cert. ef. 7-1-09; SSP 28-2009, f. & cert. ef. 10-1-09; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 17-2011, f. & cert. ef. 7-1-11; SSP 25-2011, f. 9-30-11, cert. ef. 10-1-11; SSP 13-2013, f. & cert. ef. 7-1-13

461-195-0541
Liability for Overpayments

(1) In all programs except the BCCM, CEC, CEM, EXT, GA, GAM, MAA, MAF, OHP, OSIP, OSIPM, QMB, REFM, SAC and SNAP programs or a child care program, the following persons are liable for repayment of an overpayment (see OAR 461-195-0501):

(a) Each individual in the filing group or required to be in the filing group and the payee when the overpayment was incurred, except an individual who did not reside with and did not know he or she was included in the filing group.

(b) A caretaker relative (see OAR 461-001-0000) and his or her spouse (see OAR 461-001-0000) who were not part of, but resided with, the filing group when the overpayment was incurred.

(c) A parent (see OAR 461-001-0000) or caretaker relative of a child (see OAR 461-001-0000) in the benefit group (see OAR 461-110-0750) and the spouse of the parent or caretaker relative if the parent, caretaker relative, or spouse was a member of or resided with the filing group when the overpayment was incurred.

(d) An individual determined liable for an overpayment remains liable when the individual becomes a member of a new filing group.

(e) An authorized representative (see OAR 461-115-0090) when the authorized representative gave incorrect or incomplete information or withheld information resulting in the overpayment.

(2) In the BCCM, CEC, CEM, EXT, MAA, MAF, OHP, REFM, and SAC programs, the following persons are liable for repayment of an overpayment:

(a) Each individual in the filing group or required to be in the filing group and the payee when the overpayment was incurred, except an individual who:

(A) Was a child or dependent child (see OAR 461-001-0000) at the time of the overpayment; or

(B) Did not reside with and did not know he or she was included in the filing group.

(b) A caretaker relative and his or her spouse who were not part of, but resided with, the filing group when the overpayment was incurred.

(c) A parent or caretaker relative of a child in the filing group and the spouse of the parent or caretaker relative if the parent, caretaker relative, or spouse was a member of or resided with the filing group when the overpayment was incurred.

(d) An authorized representative when the authorized representative gave incorrect or incomplete information or withheld information that resulted in the overpayment.

(3) In a child care program:

(a) An overpayment caused by administrative error is collectible as follows:

(A) The provider is liable for a provider overpayment made on behalf of a client eligible for child care payments.

(B) Each adult in the filing group or required to be in the filing group is liable for an overpayment if the client was not eligible for the payment.

(b) Each adult in the filing group or required to be in the filing group is liable for a client overpayment, and a provider is liable for an overpayment caused by the provider. The client and provider are jointly and severally liable for an overpayment caused by both. In the case of an alleged provider overpayment, a provider's failure to provide contemporaneous records of care provided creates a rebuttable presumption that the care was not provided.

(c) An adult who cosigned an application with a minor provider applicant is liable for an overpayment incurred by the minor provider.

(4) In the GA, GAM, OSIP, OSIPM, and QMB programs, the following persons are liable for repayment of an overpayment:

(a) Each individual in the filing group or required to be in the filing group and the payee when the overpayment was incurred, except an individual who:

(A) Was a child or dependent child at the time of the overpayment; or

(B) Did not reside with and did not know he or she was included in the filing group.

(b) A caretaker relative and his or her spouse who were not part of, but resided with, the filing group when the overpayment was incurred.

(c) A parent or caretaker relative of a child in the filing group and the spouse of the parent or caretaker relative if the parent, caretaker relative, or spouse was a member of or resided with the filing group when the overpayment was incurred.

(d) An authorized representative when the authorized representative knowingly gave incorrect or incomplete information or intentionally withheld information that resulted in the overpayment.

(5) In the SNAP program, the following persons are liable for repayment of an overpayment or a claim that results from the trading of a controlled substance (see OAR 461-195-0501(6)):

(a) The primary person (see OAR 461-001-0015) of any age, an ineligible student in the household, and all adults (see OAR 461-001-0015) who were members of or required to be in the filing group (see OAR 461-110-0370) when excess benefits were issued.

(b) A sponsor of a non-citizen household member if the sponsor is at fault, for payments prior to November 21, 2000.

(c) A drug or alcohol treatment center or residential care facility that acted as the authorized representative of the client.

(6) Except as provided otherwise in section (7) of this rule, in all programs, both a non-citizen and the sponsor of the non-citizen are liable for an overpayment incurred if the overpayment results from the failure of the sponsor to provide correct information (see OAR 461-145-0820 to 461-145-0840). If the sponsor had good cause (see OAR 461-195-0521(5)) for withholding the information, the sponsor is not liable for the overpayment.

(7) In the SNAP program, the sponsor of a non-citizen is not liable under section (6) of this rule for payments on or after November 21, 2000.

Stat. Auth.: ORS 411.060, 411.404, 411.816, 412.014, 412.049

Stats. Implemented: ORS 411.060, 411.087, 411.404, 411.630, 411.635, 411.640, 411.690, 411.816, 412.014, 412.049, 416.350

Hist.: AFS 3-2000, f. 1-31-00, cert. ef. 2-1-00; AFS 17-2000, f. 6-28-00, cert. ef. 7-1-00; SSP 23-2003, f. & cert. ef. 10-1-03; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 14-2005, f. 9-30-05, cert. ef. 10-1-05; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 25-2011, f. 9-30-11, cert. ef. 10-1-11; SSP 7-2013(Temp), f. & cert. ef. 3-25-13 thru 9-21-13; SSP 13-2013, f. & cert. ef. 7-1-13

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Rule Caption: Changing OARs affecting public assistance, medical assistance, or Supplemental Nutrition Assistance Program clients
Adm. Order No.: SSP 14-2013(Temp)
Filed with Sec. of State: 7-1-2013
Certified to be Effective: 7-1-13 thru 12-28-13

Notice Publication Date:
Rules Amended: 461-195-0541
Subject: OAR 461-195-0541 about liability for overpayments is being amended to make the policy for SNAP overpayment liability due to SNAP benefit trafficking clear and consistent with federal law. This change is to continue temporary changes originally adopted on 3/25/2013. This amendment also supports implementation of additional federal SNAP trafficking definitions. Under this amendment, there is overpayment liability for the buying, selling, stealing or other exchange of SNAP benefits for cash or consideration other than eligible food; the exchange of firearms, ammunition, explosives or controlled substances for SNAP benefits; purchasing a product with SNAP benefits that has a container return deposit with the intent of obtaining cash by intentionally discarding the product and returning the container for the deposit return; purchasing a product with SNAP benefits with the intent of obtaining cash or consideration other than eligible food by intentionally reselling the product purchased with SNAP benefits; and intentionally purchasing products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food.
Rules Coordinator: Annette Tesch—(503) 945-6067

461-195-0541
Liability for Overpayments

(1) In all programs except the BCCM, CEC, CEM, EXT, GA, GAM, MAA, MAF, OHP, OSIP, OSIPM, QMB, REFM, SAC and SNAP programs or a child care program, the following persons are liable for repayment of an overpayment (see OAR 461-195-0501):

(a) Each individual in the filing group or required to be in the filing group and the payee when the overpayment was incurred, except an individual who did not reside with and did not know he or she was included in the filing group.

(b) A caretaker relative (see OAR 461-001-0000) and his or her spouse (see OAR 461-001-0000) who were not part of, but resided with, the filing group when the overpayment was incurred.

(c) A parent (see OAR 461-001-0000) or caretaker relative of a child (see OAR 461-001-0000) in the benefit group (see OAR 461-110-0750) and the spouse of the parent or caretaker relative if the parent, caretaker relative, or spouse was a member of or resided with the filing group when the overpayment was incurred.

(d) An individual determined liable for an overpayment remains liable when the individual becomes a member of a new filing group.

(e) An authorized representative (see OAR 461-115-0090) when the authorized representative gave incorrect or incomplete information or withheld information resulting in the overpayment.

(2) In the BCCM, CEC, CEM, EXT, MAA, MAF, OHP, REFM, and SAC programs, the following persons are liable for repayment of an overpayment:

(a) Each individual in the filing group or required to be in the filing group and the payee when the overpayment was incurred, except an individual who:

(A) Was a child or dependent child (see OAR 461-001-0000) at the time of the overpayment; or

(B) Did not reside with and did not know he or she was included in the filing group.

(b) A caretaker relative and his or her spouse who were not part of, but resided with, the filing group when the overpayment was incurred.

(c) A parent or caretaker relative of a child in the filing group and the spouse of the parent or caretaker relative if the parent, caretaker relative, or spouse was a member of or resided with the filing group when the overpayment was incurred.

(d) An authorized representative when the authorized representative gave incorrect or incomplete information or withheld information that resulted in the overpayment.

(3) In a child care program:

(a) An overpayment caused by administrative error is collectible as follows:

(A) The provider is liable for a provider overpayment made on behalf of a client eligible for child care payments.

(B) Each adult in the filing group or required to be in the filing group is liable for an overpayment if the client was not eligible for the payment.

(b) Each adult in the filing group or required to be in the filing group is liable for a client overpayment, and a provider is liable for an overpayment caused by the provider. The client and provider are jointly and severally liable for an overpayment caused by both. In the case of an alleged provider overpayment, a provider's failure to provide contemporaneous records of care provided creates a rebuttable presumption that the care was not provided.

(c) An adult who cosigned an application with a minor provider applicant is liable for an overpayment incurred by the minor provider.

(4) In the GA, GAM, OSIP, OSIPM, and QMB programs, the following persons are liable for repayment of an overpayment:

(a) Each individual in the filing group or required to be in the filing group and the payee when the overpayment was incurred, except an individual who:

(A) Was a child or dependent child at the time of the overpayment; or

(B) Did not reside with and did not know he or she was included in the filing group.

(b) A caretaker relative and his or her spouse who were not part of, but resided with, the filing group when the overpayment was incurred.

(c) A parent or caretaker relative of a child in the filing group and the spouse of the parent or caretaker relative if the parent, caretaker relative, or spouse was a member of or resided with the filing group when the overpayment was incurred.

(d) An authorized representative when the authorized representative knowingly gave incorrect or incomplete information or intentionally withheld information that resulted in the overpayment.

(5) In the SNAP program, the following persons are liable for repayment of an overpayment or a claim that results from trafficking (see OAR 461-195-0601(2)) of SNAP benefits:

(a) The primary person (see OAR 461-001-0015) of any age, an ineligible student in the household, and all adults (see OAR 461-001-0015) who were members of or required to be in the filing group (see OAR 461-110-0370) when excess benefits were issued.

(b) A sponsor of a non-citizen household member if the sponsor is at fault, for payments prior to November 21, 2000.

(c) A drug or alcohol treatment center or residential care facility that acted as the authorized representative of the client.

(6) Except as provided otherwise in section (7) of this rule, in all programs, both a non-citizen and the sponsor of the non-citizen are liable for an overpayment incurred if the overpayment results from the failure of the sponsor to provide correct information (see OAR 461-145-0820 to 461-145-0840). If the sponsor had good cause (see OAR 461-195-0521(5)) for withholding the information, the sponsor is not liable for the overpayment.

(7) In the SNAP program, the sponsor of a non-citizen is not liable under section (6) of this rule for payments on or after November 21, 2000.

Stat. Auth.: ORS 411.060, 411.404, 411.816, 412.014, 412.049
Stats. Implemented: ORS 411.060, 411.087, 411.404, 411.630, 411.635, 411.640, 411.690, 411.816, 412.014, 412.049, 416.350
Hist.: AFS 3-2000, f. 1-31-00, cert. ef. 2-1-00; AFS 17-2000, f. 6-28-00, cert. ef. 7-1-00; SSP 23-2003, f. & cert. ef. 10-1-03; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 14-2005, f. 9-30-05, cert. ef. 10-1-05; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 25-2011, f. 9-30-11, cert. ef. 10-1-11; SSP 7-2013(Temp), f. & cert. ef. 3-25-13 thru 9-21-13; SSP 13-2013, f. & cert. ef. 7-1-13; SSP 14-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

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Rule Caption: Changing OARs affecting public assistance, medical assistance, or Supplemental Nutrition Assistance Program clients
Adm. Order No.: SSP 15-2013(Temp)
Filed with Sec. of State: 7-1-2013
Certified to be Effective: 7-1-13 thru 12-28-13
Notice Publication Date:
Rules Amended: 461-135-1100, 461-135-1101, 461-190-0211
Subject: OAR 461-135-1100 about Oregon Health Plan (OHP) eligibility requirements and OAR 461-135-1101 about Healthy KidsConnect (HKC) eligibility requirements are being amended to identify the standards by which private major medical health insurance (or Third Party Liability - TPL) may be considered inaccessible and thus does not preclude eligibility for OHP-OPU, OHP-CHP, and Healthy KidsConnect (HKC) programs.

OAR 461-190-0211 about case plan activities and standards for support service payments for the Department's Temporary Assistance for Needy Families Job Opportunity and Basic Skills (JOBS) program is being amended to modify program restrictions implemented July 1, 2011 as a result of budget reductions from the 2011 legislative session. This amendment promotes local JOBS service delivery in a way that better responds to local service and client

needs. The changes expand the JOBS contracted services array to add crisis intervention family stability activities. High School and GED services are no longer limited only to teen parents. Support services payments will be allowed for life skills, on-the-job training, adult basic education, and SSI application process. Support services child care will be available for two-parent families.
Rules Coordinator: Annette Tesch—(503) 945-6067

461-135-1100
Specific Requirements; OHP

In addition to eligibility requirements applicable to the OHP program in other rules in chapter 461 of the Oregon Administrative Rules, this rule sets out specific eligibility requirements for the OHP program.

(1) For purposes of this rule, OAR 461-135-1101, and 461-135-1149, the term private major medical health insurance refers to a comprehensive major medical insurance plan that at a minimum provides physician services; hospitalization (inpatient and outpatient); outpatient lab, x-ray, immunizations; and prescription drug coverage. This term does not include coverage under the Kaiser Child Health Program or Kaiser Transition Program but does include policies that are purchased privately or are employer-sponsored.

(2) To be eligible for the OHP program, an individual cannot:

(a) Be receiving, or deemed to be receiving, SSI benefits;

(b) Be eligible for Medicare, except that this requirement does not apply to the OHP OPP program;

(c) Be receiving Medicaid through another program; or

(d) Be enrolled in a health insurance plan subsidized by the Family Health Insurance Assistance program (FHIAP, see ORS 735.720 to 735.740).

(3) To be eligible for the OHP-OPU program, an individual must be 19 years of age or older and may not be pregnant. An individual eligible for the OHP-OPU program is referred to as a health plan new/noncategorical (HPN) client. In addition to all other OHP program eligibility requirements, an HPN client:

(a) May not be covered by private major medical health insurance that is accessible to the HPN client. For the purposes of this rule, an individual may be eligible for OHP-OPU if they have private major medical health insurance that is not accessible for one or more of the following reasons:

(A) The travel time or distance to available providers exceeds:

(i) In urban areas — 30 miles, 30 minutes, or the community standard, whichever is greater;

(ii) In rural areas — 60 miles, 60 minutes, or the community standard, whichever is greater.

(B) Accessing the private major medical health insurance would place a filing group member at risk of harm.

(b) May not have been covered by private major medical health insurance during the six months preceding the effective date for starting medical benefits. The six-month waiting period is waived if:

(A) The criteria in subsection (a) of this section are met.

(B) The individual has a condition that, without treatment, would be life-threatening or would cause permanent loss of function or disability;

(C) The individual's private health insurance premium was reimbursed under the provisions of OAR 461-135-0990;

(D) The individual's private health insurance was subsidized through FHIAP or the Office of Private Health Partnerships (OPHP) in accordance with ORS 414.231, 414.826, 414.831, and 414.839; or

(E) A member of the individual's filing group was a victim of domestic violence.

(c) Must meet the following eligibility requirements:

(A) The resource limit provided in OAR 461-160-0015;

(B) Payment of premiums determined in accordance with OAR 461-155-0235 and paid in accordance with OAR 461-135-1120; and

(C) The requirements in OAR 461-120-0345 related to obtaining medical coverage for members of the benefit group through the Family Health Insurance Assistance Program (FHIAP), if applicable.

(4) To be eligible for the OHP-OPC program, an individual must be less than 19 years of age.

(5) To be eligible for the OHP-OP6 program, a child must be less than six years of age and not eligible for OHP-OPC.

(6) To be eligible for the OHP-OPP program, an individual must be pregnant or must be a newborn assumed eligible under OAR 461-135-0010(4).

(7) To be eligible for the OHP-CHP program, an individual must be under 19 years of age and must:

(a) Not be eligible for the OHP-OPC, OHP-OPP, or OHP-OP6 programs;

(b) Meet budgeting requirements of OAR 461-160-0700;

(c) For eligibility decisions prior to August 16, 2010, select a medical, dental and mental health managed health care plan (MHCP) or primary care case manager (PCCM) if available, unless the client is exempted by OAR 410-141-0060; and

(d) Not be covered by any private major medical health insurance. For the purposes of this rule, an individual may be eligible for OHP-CHP if they have private major medical health insurance that is not accessible for one or more of the following reasons:

(A) The travel time or distance to available providers exceeds:

(i) In urban areas — 30 miles, 30 minutes, or the community standard, whichever is greater;

(ii) In rural areas — 60 miles, 60 minutes, or the community standard, whichever is greater.

(B) Accessing the private major medical health insurance would place a filing group member at risk of harm.

(e) Not be covered by private major medical health insurance during the two months preceding the effective date for starting medical benefits. The two-month waiting period is waived if:

(A) The criteria in subsection (d) of this section are met.

(B) The individual has a condition that, without treatment, would be life threatening or cause permanent loss of function or disability;

(C) The loss of health insurance was due to the loss of or a change in employment;

(D) The individual's private health insurance premium was reimbursed under OAR 461 135 0990;

(E) The individual's private health insurance was subsidized through FHIAP or the Office of Private Health Partnerships (OPHP) in accordance with ORS 414.231, 414.826, 414.831, and 414.839; or

(F) A member of the individual's filing group was a victim of domestic violence.

(8) A child who becomes ineligible for the OHP program because of age while receiving in patient medical services remains eligible until the end of the month in which he or she no longer receives those services if he or she is receiving in-patient medical services on the last day of the month in which the age requirement is no longer met.

(9) In the HKC, OHP-CHP, and OHP-OPC programs, for the Department to enroll a child in the program based on a determination made by an ELA, the child's parent or guardian must give consent in writing, by telephone, orally, or through electronic signature for the child to be enrolled in the program.

(10) The Department only may use ELE for a child in a filing group in which no member is already receiving benefits through the CEC, CEM, EXT, HKC, MAA, MAF, OHP-CHP, OHP-OPP, OHP-OP6, OSIPM, or SAC program.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 411.706, 414.115, 414.231
Stats. Implemented: ORS 409.010, 411.060, 411.070, 411.404, 411.704, 411.706, 414.025, 414.115, 414.231, 414.826, 414.831, 414.839
Hist.: AFS 2-1994, f. & cert. ef. 2-1-94; AFS 13-1994, f. & cert. ef. 7-1-94; AFS 29-1994, f. 12-29-94, cert. ef. 1-1-95; AFS 22-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 41-1995, f. 12-26-95, cert. ef. 1-1-96; AFS 27-1996, f. 6-27-96, cert. ef. 7-1-96; AFS 36-1996, f. 10-31-96, cert. ef. 11-1-96; AFS 3-1997, f. 3-31-97, cert. ef. 4-1-97; AFS 10-1998, f. 6-29-98, cert. ef. 7-1-98; AFS 17-1998, f. & cert. ef. 10-1-98; AFS 15-1999, f. 11-30-99, cert. ef. 12-1-99; AFS 6-2001, f. 3-30-01, cert. ef. 4-1-01; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 14-2005, f. 9-30-05, cert. ef. 10-1-05; SSP 8-2006, f. & cert. ef. 6-1-06; SSP 13-2008(Temp), f. 5-30-08, cert. ef. 6-1-08 thru 6-30-08; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 29-2009(Temp), f. & cert. ef. 10-1-09 thru 3-30-10; SSP 36-2009(Temp), f. & cert. ef. 12-1-09 thru 12-31-09; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 39-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SSP 9-2010(Temp), f. & cert. ef. 4-21-10 thru 6-30-10; SSP 18-2010, f. & cert. ef. 7-1-10; SSP 21-2010(Temp), f. & cert. ef. 7-1-10 thru 10-18-10; SSP 24-2010(Temp), f. & cert. ef. 7-15-10 thru 10-18-10; SSP 27-2010(Temp), f. & cert. ef. 8-16-10 thru 10-18-10; SSP 30-2010(Temp), f. & cert. ef. 8-25-10 thru 10-18-10; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 35-2010(Temp), f. & cert. ef. 10-1-10 thru 3-30-11; SSP 41-2010, f. 12-30-10, cert. ef. 1-1-11; SSP 36-2011(Temp), f. 12-27-11, cert. ef. 1-1-12 thru 6-29-12; SSP 9-2012, f. 3-29-12, cert. ef. 4-1-12; SSP 15-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-135-1101
Specific Requirements; Healthy KidsConnect (HKC)

In addition to the eligibility requirements applicable to the HKC program in other rules in chapter 461 of the Oregon Administrative Rules, this rule sets out specific eligibility requirements for the HKC program.

(1) To be eligible for HKC, an individual must be under 19 years of age, and:

(a) May not be covered by private major medical health insurance (see OAR 461-135-1100). An individual may be eligible for HKC if they have private major medical health insurance that is not accessible for one or more of the following reasons:

(A) The travel time or distance to available providers exceeds:

(i) In urban areas — 30 miles, 30 minutes, or the community standard, whichever is greater;

(ii) In rural areas — 60 miles, 60 minutes, or the community standard, whichever is greater.

(B) Accessing the private major medical health insurance would place a filing group member at risk of harm.

(b) May not have been covered by private major medical health insurance during the two months preceding the effective date for starting medical benefits. The two-month waiting period is waived if:

(A) The criteria in subsection (a) of this section are met.

(B) The individual has a condition that, without treatment, would be life-threatening or cause permanent loss of function or disability;

(C) The loss of health insurance was due to a change in employment;

(D) The individual's private health insurance premium was reimbursed under OAR 461-135-0990;

(E) The individual's private health insurance premium was subsidized by FHIAP or by the Office of Private Health Partnerships (OPHP); or

(F) A member of the individual's filing group was a victim of domestic violence.

(2) Income treatment and availability of income requirements used for determining HKC program eligibility are the same as used for the OHP-CHP program in this chapter of the administrative rules.

(3) Budgeting for HKC program eligibility follows the same methodologies as those used for the OHP-CHP program under OAR 461-150-0055.

(4) The countable income standard for the HKC program is at or above 201 percent of the federal poverty limit, in accordance with ORS 414.231 and 414.826.

(5) To be eligible for the HKC program, a child must be a U.S. citizen or meet the alien status requirements as provided in OAR 461-120-0125.

(6) Once approved for the HKC program, the child is referred to OPHP in accordance with ORS 414.231, 414.826, 414.831, and 414.839. OPHP may enroll the child in one of the following program categories:

(a) Healthy KidsConnect Employer Sponsored Insurance (ESI);

(b) Healthy KidsConnect subsidy; or

(c) Healthy KidsConnect full pay.

(7) The eligibility period for the HKC program is a 12-month period. Once a child is approved as eligible for the HKC program, the child is referred to OPHP for enrollment. The enrollment period begins on the date OPHP enrolls the child and may continue through the remainder of the 12-month eligibility period.

(8) A child found eligible for the HKC program under this rule becomes ineligible if any of the following occur:

(a) The child reaches 19 years of age.

(b) The child begins coverage under private major medical health insurance and the insurance is accessible (subsection (a) of this section) and is not provided through a contract with OPHP.

(c) The child becomes a resident of a state other than Oregon.

(d) The child's share of the HKC program insurance premium is not paid.

(e) OPHP determines the child no longer qualifies for enrollment through OPHP.

(f) The Department determines the child does not meet the requirements for eligibility, including but not limited to the child's failure to re-enroll in the HKC program before the end of the HKC program eligibility period.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 414.025, 414.231, 414.826, 414.831, 414.839

Stats. Implemented: ORS 411.060, 411.070, 411.404, 414.025, 414.231, 414.826, 414.831, 414.839

Hist: SSP 39-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SSP 18-2010, f. & cert. ef. 7-1-10; SSP 15-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-190-0211

Case Plan Activities and Standards for Support Service Payments; JOBS, Post-TANF, Pre-TANF, REF, SFPSS, TA-DVS, TANF

In the JOBS, Post-TANF, Pre-TANF, REF, SFPSS, TA-DVS, and TANF programs, notwithstanding any other administrative rule in chapter 461 and subject to the limitations of state funding, the following special provisions apply:

(1) Participation in an activity (see OAR 461-001-0025) is limited as provided in each of the following subsections:

(a) An individual who is determined to be a work-eligible individual according to federal definition (45 CFR 261.2(n)(1)). Unless section (10) of this rule applies, no other individual may participate in and access JOBS contract activities and support services (see OAR 461-001-0025).

(b) An individual who is an applicant in the Pre-TANF program or a recipient of TANF or Post-TANF program benefits.

(2) For eligible individuals, subject to the requirements and limitations in sections (1), (5), (6), and (7) of this rule, the following activities will be available, and include support services payments if needed:

(a) Job search (see OAR 461-001-0025).

(b) JOBS Plus (see OAR 461-001-0025 and 461-101-0010) is limited to six months per individual, unless circumstances unique to the employment situation are identified and warrant the Department to approve a limited number of additional months.

(c) Work experience (see OAR 461-001-0025).

(d) Sheltered or supported work (see OAR 461-001-0025).

(e) High School or GED Completion Attendance (see OAR 461-001-0025).

(f) Parents as Scholars (see OAR 461-001-0025).

(g) Limited family stability (see OAR 461-001-0000).

(A) Drug and alcohol services (see OAR 461-001-0025).

(B) Mental health services (see OAR 461-001-0025).

(C) Attending medical appointments or services.

(D) Rehabilitative activities (see OAR 461-001-0025).

(E) Crisis Intervention (see OAR 461-001-0025).

(h) Vocational training (see OAR 461-001-0025).

(i) Life Skills (see OAR 461-001-0025).

(j) On-the-job training (see OAR 461-001-0025).

(k) SSI Application Process.

(l) Unsubsidized employment (work).

(m) Adult Basic Education (see OAR 461-001-0025).

(3) The following activities will not include support services payments:

(a) Domestic Violence Intervention.

(b) Family Support & Connections.

(c) Post-TANF.

(d) Program entry (see OAR 461-001-0025).

(e) Self Initiated Training (see OAR 461-001-0025).

(4) Participation in an activity is based on whether an individual is Job Ready, Near Job Ready, Not Job Ready, or a teen parent (see OAR 461-001-0000 and 461-001-0025).

(a) Job Ready means the individual has no barrier (see OAR 461-001-0025) or current barriers do not impact participation or employment. In addition, the individual has all of the following:

(A) Prior stable work history, either paid or unpaid.

(B) Had not voluntarily quit or been dismissed from their most recent employment (see OAR 461-135-0070), without good cause (see OAR 461-135-0070).

(C) Reliable or available transportation.

(D) No outstanding legal issues that would impact or prevent employment.

(E) Access to reliable child care within support services limits, or does not need help to pay for child care, or does not need child care.

(b) Near Job Ready means the individual has minimal barriers to participation or employment and the individual is addressing the barriers. In addition, the individual has all of the following:

(A) Limited or no work history, either paid or unpaid.

(B) Reliable or available transportation.

(C) No outstanding legal issues that would impact or prevent employment, or such legal issues are identified and are being addressed.

(D) Access to reliable child care within support services limits, or does not need help to pay for child care, or does not need child care.

(c) Not Job Ready means the individual has one or more barriers to participation or employment or is in crisis, and the individual is not addressing the barriers. For example, the individual has one or more of the following:

(A) Lack of stable housing that is preventing participation in an activity or employment.

(B) Domestic violence, mental health or alcohol and drug issues, and the individual is not addressing the issue.

(C) Medical issues that prevent participation in an activity or employment.

(D) Outstanding legal issues that would impact or prevent employment.

(E) Literacy issues that impact the ability for the individual to participate in an activity or obtain employment.

(5) In approving JOBS program support services payments, the Department must consider lower cost alternatives. It is not the intent of the Department or of this rule to supplant Department funding with other fund-

ing that is available in the community. It is the Department's expectation that case managers and clients will work collaboratively to seek resources that are reasonably available to the client in order to participate in activities.

(6) Payments for support services are only provided when:

(a) Necessary to participate in activities in a signed case plan;

(b) Authorized in advance; and

(c) All other provisions of this rule are met.

(7) Payments for support services are subject to the following limitations:

(a) Child Care. Payments for child care may be authorized, as limited by OAR 461-160-0040, if necessary to enable Job Ready or Near Job Ready individuals or teen parents to participate in an approved JOBS program activity specified in the individual's case plan, or a Not Job Ready individual approved by the district to complete a family stability activity. If authorized, payment for child care will be:

(A) The lesser of the actual rate charged by the care provider and the rate established in OAR 461-155-0150. The Department rate for children in care less than 158 hours in a month is limited by OAR 461-155-0150.

(B) The minimum hours necessary, including meal and commute time, for the individual to participate in an approved JOBS program activity.

(b) Transportation. The Department may provide payments for a Job Ready or Near Job Ready individual or teen parent for transportation costs incurred in travel to and from an approved JOBS program activity or a Not Job Ready individual approved by the district to complete a family stability activity. Payment is made only for the cost of public transportation or the cost of fuel. Payments are subject to the following considerations:

(A) Payment for public transportation is a priority over payment for a privately owned vehicle.

(B) Payment for fuel costs for a privately-owned vehicle is only provided if the client or individual providing the transportation has a valid driver's license and vehicle insurance and either of the following is true:

(i) No public transportation is available or the client is unable to use public transportation because of a verifiable medical condition or disability for which no accommodation is available.

(ii) Public transportation is available but is more costly than the cost of fuel.

(c) Housing and Utilities. Payments for housing and utilities are not allowed.

(d) Other Payments. When the need is identified by the district and no other sources are available, the Department may provide other payments needed:

(A) To look for work.

(B) To accept a job offer.

(C) To attain a high school diploma or GED.

(D) For books and supplies for a participant to complete a district-approved vocational training.

(E) Other payments with manager approval that are not otherwise restricted by rule.

(e) None of the following payments are allowed:

(A) Non-essential items.

(B) Television, cable, and internet.

(C) Fines, reinstatement fees, restitution, legal fees, civil fees, court costs, or other costs associated with a penalty.

(D) Purchase of a car, recreational vehicle, or motor home.

(E) Support services for exempt individuals.

(F) Pet-related costs.

(G) ERDC co-payments.

(8) The Department may require an individual to provide verification of a need for, or costs associated with, support services prior to approval and issuance of payment if verification is reasonably available.

(9) The Department may reduce, close, or deny in whole or in part an individual's request for a support services payment in the following circumstances:

(a) The individual is disqualified for failing to comply with a case plan, unless the payment in question is necessary for the individual to demonstrate cooperation with his or her case plan.

(b) The purpose for the payment is not related to the individual's case plan.

(c) The individual disagrees with a support services payment offered or made by the Department as outlined in the individual's case plan.

(d) The individual is not determined to be a Job Ready or Near Job Ready individual, a Not Job Ready individual in a family stability activity, or a teen parent.

(10) An individual who has gone over-income for the TANF program due to earnings and needs to increase activity hours to meet Post-TANF federally required participation rates (see OAR 461-001-0025) may be a volunteer and participate.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 412.006, 412.009, 412.014, 412.049, 412.124 & 2011 OL 604

Stats. Implemented: ORS 409.010, 411.060, 411.070, 412.001, 412.006, 412.009, 412.014, 412.049, 412.124 & 2011 OL 604

Hist.: AFS 23-1990, f. 9-28-90, cert. ef. 10-1-90; AFS 30-1990, f. 12-31-90, cert. ef. 1-1-91; AFS 9-1991, f. 3-29-91, cert. ef. 4-1-91; AFS 20-1992, f. 7-31-92, cert. ef. 8-1-92; AFS 12-1993, f. & cert. ef. 7-1-93; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 26-1996, f. 6-27-96, cert. ef. 7-1-96; AFS 36-1996, f. 10-31-96, cert. ef. 11-1-96; AFS 18-1998, f. & cert. ef. 10-2-98; AFS 2-1999, f. 3-26-99, cert. ef. 4-1-99; AFS 3-2000, f. 1-31-00, cert. ef. 2-1-00; SSP 33-2003, f. 12-31-03, cert. ef. 1-4-04; SSP 21-2004, f. & cert. ef. 10-1-04; SSP 11-2005(Temp), f. & cert. ef. 9-1-05 thru 12-31-05; SSP 19-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 11-2007(Temp), f. & cert. ef. 10-1-07 thru 3-29-08; SSP 5-2008, f. 2-29-08, cert. ef. 3-1-08; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 42-2010(Temp), f. 12-30-10, cert. ef. 1-1-11 thru 6-30-11; SSP 10-2011, f. 3-31-11, cert. ef. 4-1-11; SSP 19-2011(Temp), f. & cert. ef. 7-1-11 thru 12-28-11; SSP 25-2011, f. 9-30-11, cert. ef. 10-1-11; SSP 30-2011(Temp), f. & cert. ef. 11-1-11 thru 4-29-12; SSP 11-2012, f. & cert. ef. 4-6-12; SSP 12-2012(Temp), f. & cert. ef. 4-6-12 thru 9-30-12; SSP 18-2012(Temp), f. & cert. ef. 5-23-12 thru 9-30-12; SSP 30-2012, f. 9-28-12, cert. ef. 10-1-12; SSP 34-2012(Temp), f. & cert. ef. 11-6-12 thru 5-5-13; SSP 38-2012(Temp), f. 12-28-12, cert. ef. 1-1-13 thru 5-5-13; SSP 2-2013(Temp), f. & cert. ef. 1-23-13 thru 5-5-13; SSP 8-2013, f. & cert. ef. 4-1-13; SSP 15-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

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Rule Caption: Changing OARs affecting public assistance, medical assistance, or Supplemental Nutrition Assistance Program clients

Adm. Order No.: SSP 16-2013(Temp)

Filed with Sec. of State: 7-1-2013

Certified to be Effective: 7-1-13 thru 12-28-13

Notice Publication Date:

Rules Amended: 461-160-0620

Subject: OAR 461-160-0620, relating to the liability calculation for clients in the Oregon Supplemental Income Program Medical (OSIPM, assistance to seniors and people with disabilities) receiving long-term care services, is being amended to reflect the annual federal increase to the minimum maintenance need standard and shelter standard that are used to calculate how much of the client's income can be diverted to the community spouse. This rule is also being amended due to changes in Medicaid funding for community-based care. Some community-based care that was previously funded through Medicaid waivers will now be funded under the State Medicaid Plan. This amendment removes references to waivered care, and as appropriate, replaces the references with references to home and community-based care. Removing references to waivered care will allow the Department to provide community-based care services under Medicaid waivers or under the Medicaid State Plan, as appropriate, to reflect the change in funding.

Rules Coordinator: Annette Tesch—(503) 945-6067

461-160-0620

Income Deductions and Client Liability; Long-Term Care Services or Home and Community-Based Care; OSIPM

In the OSIPM program:

(1) Deductions from income are made for a client residing in or entering a long-term care facility or receiving home and community-based care (see OAR 461-001-0030) as explained in subsections (3)(a) to (3)(h) of this rule.

(2) Except as provided otherwise in OAR 461-160-0610, the liability of the client is determined according to subsection (3)(i) of this rule.

(3) Deductions are made in the following order:

(a) One standard earned income deduction of $65 is made from the earned income in the OSIPM-AD and OSIPM-OAA programs. The deduction is $85 in the OSIPM-AB program.

(b) The deductions under the plan for self-support as allowed by OAR 461-145-0405.

(c) One of the following need standards:

(A) A $30 personal needs allowance for a client receiving long-term care services.

(B) A $90 personal needs allowance for a client receiving long-term care services who is eligible for VA benefits based on unreimbursed medical expenses. The $90 allowance is allowed only when the VA benefit has been reduced to $90.

(C) The OSIPM maintenance standard for a client who receives home and community-based care.

(d) A community spouse monthly income allowance is deducted from the income of the institutionalized spouse to the extent that the income is made available to or for the benefit of the community spouse, using the following calculation.

(A) Step 1 — Determine the maintenance needs allowance. $1,939 is added to the amount over $582 that is needed to pay monthly shelter expenses for the principal residence of the couple. This sum or $2,898 whichever is less, is the maintenance needs allowance. For the purpose of this calculation, shelter expenses are the rent or home mortgage payment (principal and interest), taxes, insurance, required maintenance charges for a condominium or cooperative, and the full standard utility allowance for the SNAP program (see OAR 461-160-0420).

(B) Step 2 — Compare maintenance needs allowance with community spouse's countable income. The countable income of the community spouse is subtracted from the maintenance needs allowance determined in step 1. The difference is the income allowance unless the allowance described in step 3 is greater.

(C) Step 3 — If a spousal support order or exceptional circumstances resulting in significant financial distress require a greater income allowance than that calculated in step 2, the greater amount is the allowance.

(e) A dependent income allowance as follows:

(A) For a case with a community spouse, a deduction is permitted only if the monthly income of the eligible dependent is below $1,939. To determine the income allowance of each eligible dependent:

(i) The monthly income of the eligible dependent is deducted from $1,939.

(ii) One-third of the amount remaining after the subtraction in paragraph (A) of this subsection is the income allowance of the eligible dependent.

(B) For a case with no community spouse:

(i) The allowance is the TANF adjusted income standard for the client and eligible dependents.

(ii) The TANF standard is not reduced by the income of the dependent.

(f) Costs for maintaining a home if the client meets the criteria in OAR 461-160-0630.

(g) Medical deductions allowed by OAR 461-160-0030 and 461-160-0055 are made for costs not covered under the state plan. This includes the public and private health insurance premiums of the community spouse and the client's dependent.

(h) After taking all the deductions allowed by this rule, the remaining balance is the adjusted income.

(i) The client liability is determined as follows:

(A) For a client receiving home and community-based care (except a client identified in OAR 461-160-0610(4)), the liability is the actual cost of the home and community-based care or the adjusted income of the client, whichever is less. This amount must be paid to the Department each month as a condition of being eligible for home and community-based care. In OSIPM-IC, the liability is subtracted from the gross monthly benefit.

(B) For a client who resides in a nursing facility, a state psychiatric hospital, an Intermediate Care Facility for the Mentally Retarded, or a mental health facility, there is a liability as described at OAR 461-160-0610.

(4) The deduction used to determine adjusted income for a GA and GAM client receiving long-term care services or home and community-based care is as follows:

(a) One standard earned income deduction of $65 is made from the earned income for a client who is not blind; or

(b) One standard earned income deduction of $85 is made from the earned income for a client who is blind.

Stat. Auth.: ORS 411.060, 411.070 & 411.706

Stats. Implemented: ORS 411.060, 411.070 & 411.706

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 16-1990, f. 6-29-90, cert. ef. 7-1-90; AFS 13-1991. f. & cert. ef. 7-1-91; AFS 8-1992, f. & cert. ef. 4-1-92; AFS 17-1992, f. & cert. ef. 7-1-92; AFS 28-1992, f. & cert. ef. 10-1-92; AFS 5-1993, f. & cert. ef. 4-1-93; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 6-1994, f. & cert. ef. 4-1-94; AFS 29-1994, f. 12-29-94, cert. ef. 1-1-95; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 23-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 15-1996, f. 4-29-96, cert. ef. 5-1-96; AFS 5-1997, f. 4-30-97, cert. ef. 5-1-97; AFS 6-1998(Temp), f. 3-30-98, cert. ef. 4-1-98 thru 5-31-98; AFS 8-1998, f. 4-28-98, cert. ef. 5-1-98; AFS 1-1999(Temp), f. & cert. ef. 2-1-99 thru 7-31-99; AFS 3-1999, f. 3-31-99, cert. ef. 4-1-99; AFS 6-1999, f. & cert. ef. 4-22-99; AFS 3-2000, f. 1-31-00, cert. ef. 2-1-00; AFS 10-2000, f. 3-31-00, cert. ef. 4-1-00; AFS 17-2000, f. 6-28-00, cert. ef. 7-1-00; AFS 25-2000, f. 9-29-00, cert. ef. 10-1-00; AFS 6-2001, f. 3-30-01, cert. ef. 4-1-01; AFS 11-2001, f. 6-29-01, cert. ef. 7-1-01; AFS 5-2002, f. & cert. ef. 4-1-02; AFS 10-2002, f. & cert. ef. 7-1-02; AFS 22-2002, f. 12-31-02, cert. ef. 1-1-03; SSP 16-2003, f. & cert. ef. 7-1-03; SSP 23-2003, f. & cert. ef. 10-1-03; SSP 33-2003, f. 12-31-03, cert. ef. 1-4-04; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 7-2005, f. & cert. ef. 7-1-05; SSP 8-2005(Temp), f. & cert. ef. 7-1-05 thru 10-1-05; SSP 9-2005(Temp), f. & cert. ef. 7-6-05 thru 10-1-05; SSP 14-2005, f. 9-30-05, cert. ef. 10-1-05; SSP 19-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; SSP 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 14-2007, f. 12-31-07, cert. ef. 1-1-08; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 13-2009, f. & cert. ef. 7-1-09; SSP 18-2011(Temp), f. & cert. ef. 7-1-11 thru 12-28-11; SSP 25-2011, f. 9-30-11, cert. ef. 10-1-11; SSP 35-2011, f. 12-27-11, cert. ef. 1-1-12; SSP 23-2012(Temp), f. 6-29-12, cert. ef. 7-1-12 thru 12-28-12; SSP 30-2012, f. 9-28-12, cert. ef. 10-1-12; SSP 37-2012, f. 12-28-12, cert. ef. 1-1-13; SSP 16-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

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Rule Caption: Changing OARs affecting public assistance, medical assistance, or Supplemental Nutrition Assistance Program clients

Adm. Order No.: SSP 17-2013(Temp)

Filed with Sec. of State: 7-1-2013

Certified to be Effective: 7-1-13 thru 12-28-13

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Rules Amended: 461-001-0030, 461-025-0310, 461-025-0315, 461-110-0210, 461-135-0726, 461-135-0750, 461-135-0832, 461-135-0835, 461-140-0296, 461-145-0540, 461-145-0580, 461-155-0020, 461-155-0270, 461-155-0530, 461-155-0575, 461-155-0580, 461-155-0630, 461-155-0640, 461-155-0660, 461-160-0055, 461-160-0540, 461-160-0550, 461-160-0551, 461-160-0610, 461-165-0100, 461-175-0230, 461-180-0044, 461-185-0050, 461-195-0521

Subject: OAR 461-001-0030, 461-025-0310, 461-025-0315, 461-110-0210, 461-135-0726, 461-135-0750, 461-135-0832, 461-135-0835, 461-140-0296, 461-145-0540, 461-145-0580, 461-155-0020, 461-155-0270, 461-155-0530, 461-155-0575, 461-155-0580, 461-155-0630, 461-155-0640, 461-155-0660, 461-160-0055, 461-160-0540, 461-160-0550, 461-160-0551, 461-160-0610, 461-165-0100, 461-175-0230, 461-180-0044, 461-185-0050, 461-195-0521, about medical assistance programs are being amended due to a change in Medicaid funding for community-based care. Some community-based care that was previously funded through Medicaid waivers will now be funded under the State Medicaid Plan. Rules being amended removes references to waivered care as appropriate, and as appropriate, replace the references with references to home and community-based care. Other clarifying changes are also being made. Removing references to waivered care will allow the Department to provide community-based care services under Medicaid waivers or under the Medicaid State Plan, as appropriate, to reflect the change in funding.

Rules Coordinator: Annette Tesch—(503) 945-6067

461-001-0030

Definitions; OSIP, OSIPM Long-Term Care or Home and Community-Based Care

These terms apply to rules in Chapter 461 about OSIP and OSIPM long-term care and home and community-based care clients:

(1) Community spouse: An individual who is legally married (see OAR 461-001-0000) to an institutionalized spouse and is not in a medical institution or nursing facility.

(2) Continuous period of care: Reside for a period of at least 30 consecutive days or until death in a long term care facility, home and community-based care setting, or an acute care hospital. There must be sufficient evidence to show there is a reasonable expectation that the client will remain in care for at least 30 consecutive days. For the purposes of this policy, an interruption in care (for example, leaving and then returning to a nursing home, or switching from one type of care to another) that lasts less than 30 days is not considered a break in the 30 consecutive days of care. A new period of care begins if care is interrupted for 30 or more days.

(3) Eligible dependent:

(a) For cases with a community spouse, an eligible dependent is a minor (under the age of 21) or dependent child, dependent parent, or dependent sibling of the institutionalized or community spouse who is residing with the community spouse and claimed as a tax dependent by either spouse.

(b) For cases without a community spouse, an eligible dependent is a minor (under the age of 21) or dependent child residing with and claimed as a tax dependent by the client.

(4) Home and community-based care: Title XIX services needed to keep an individual out of a long-term care facility. These services are:

(a) In-home services except for state plan personal care services.

(b) Residential care facility services.

(c) Assisted living facility services.

(d) Adult foster care services.

(e) Home adaptations to accommodate a client's physical condition.

(f) Home-delivered meals provided in conjunction with in-home services.

(g) Specialized living facility services.

(h) Adult day care services.

(i) Community transition services.

(5) Home and community-based care client: A client receiving home and community-based care for a continuous period.

(6) Institutionalized spouse: An individual who is in long-term care or receiving home and community-based care for a continuous period and is married to a community spouse.

Stat. Auth.: ORS 411.060

Stats. Implemented: ORS 411.060, 411.700

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 2-1992, f. 1-30-92, cert. ef. 2-1-92; AFS 6-1994, f. & cert. ef. 4-1-94; AFS 29-1994, f. 12-29-94, cert. ef. 1-1-95; AFS 23-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 3-2000, f. 1-31-00, cert. ef. 2-1-00; AFS 5-2002, f. & cert. ef. 4-1-02; SSP 8-2004, f. & cert. ef. 4-1-04; SSP 4-2005, f. & cert. ef. 4-1-05; Renumbered from 461-160-0560, SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 13-2009, f. & cert. ef. 7-1-09; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-025-0310

Hearing Requests

(1) A claimant (see OAR 461-025-0305) has the right to a contested case hearing in the following situations upon the timely completion of a request for hearing:

(a) Except as provided in subsection (o) of this section, the Department has not approved or denied a request or application for public assistance within 45 days of the application.

(b) The Department has not acted timely on an application as follows:

(A) An application for SNAP program benefits – within 30 days of the filing date.

(B) An application for a JOBS support service payment – within the time frames established in OAR 461-115-0190(3).

(c) The Department acts to deny, reduce, close, or suspend SNAP program benefits, a grant of public assistance, a grant of aid, a support service payment authorized in the JOBS program by OAR 461-190-0211, medical assistance, or child care benefits authorized under division 160 or 165 of this chapter of rules in the ERDC or TANF child care programs. When used in this subsection, grant of public assistance and grant of aid mean the grant of cash assistance calculated according to the client's need.

(d) The Department claims that an earlier public assistance payment was an overpayment, or that an earlier issuance of SNAP program benefits was an overissuance.

(e) The Department modifies a grant of public assistance or a grant of aid; or the claimant claims that the Department previously underissued public assistance or SNAP program benefits and the Department denies, or denies in part, that claim.

(f) The household disputes its current level of SNAP program benefits.

(g) The filing group (see OAR 461-110-0370) is aggrieved by any action of the Department that affects the participation of the filing group in the SNAP program.

(h) The claimant asks for a hearing to determine if the waiver of an Intentional Program Violation hearing was signed under duress.

(i) The Department establishes or changes the client's premium for the Oregon Health Plan.

(j) In the Pre-TANF program, the Department denies payment for a basic living expense (see OAR 461-135-0475) or other support service payment in the JOBS program (see subsection (c) of this section).

(k) In the TA-DVS program, when OAR 461-135-1235 provides a right to a hearing.

(l) A service re-assessment of a client conducted in accordance with OAR division 411-015 has resulted in a reduction or termination of nursing facility services or home and community-based care (see OAR 461-001-0030).

(m) The claimant's benefits are changed to vendor, protective, or two-party payments.

(n) Department has issued a notice seeking repayment under ORS 411.892 to an employer participating in the JOBS program.

(o) In the OSIP and OSIPM programs, when the Department has not approved or denied an application within the time frames established in OAR 461-115-0190.

(p) The right to a hearing is otherwise provided by statute or rule.

(2) A client is not entitled to a hearing on the question of the contents of a case plan (defined in OAR 461-190-0151) unless the right to hearing is specifically authorized by the Department's rules. For a dispute about an activity in the JOBS program, the client is entitled to use the Department's re-engagement process (see OAR 461-190-0231). In the TA-DVS program, a dispute about the contents of a TA-DVS case plan (see OAR 461-135-1205) is resolved through re-engagement if there is no right to a hearing under OAR 461-135-1235.

(3) A request for hearing is complete:

(a) In public assistance and SNAP programs, when the Department's Administrative Hearing Request form (form DHS 443) is:

(A) Completed;

(B) Signed by the claimant, the claimant's attorney, or the claimant's authorized representative (see OAR 461-115-0090); and

(C) Received by the Department. OAR 137-003-0528(1)(a) (which allows hearing requests to be treated as timely based on the date of the postmark) does not apply to hearing requests contesting a decision notice (see OAR 461-001-0000). The Department has adopted the exception to the Attorney General's model rules set out in this paragraph due to operational conflicts.

(b) In the SNAP program, when the Department receives an oral or written statement from the claimant, the claimant's attorney, or the claimant's authorized representative that the claimant wishes to appeal a decision affecting the claimant's SNAP program benefits to a higher authority.

(c) In the case of a provider of child care, when a written request for hearing from the provider is received by the Department.

(4) In the event a request for hearing is not timely, the Department may issue an order of dismissal if there is no factual dispute about whether sections (7) and (10) of this rule provide a right to a hearing. The Department may refer an untimely request to the Office of Administrative Hearings for a hearing on the question of timeliness.

(5) In the event the claimant has no right to a contested case hearing on an issue, the Department may enter an order accordingly. The Department may refer a hearing request to the Office of Administrative Hearings for a hearing on the question of whether the claimant has the right to a contested case hearing.

(6) To be timely, a completed hearing request must be received by the Department not later than:

(a) Except as provided in subsection (b) of this section, the 45th day following the date of the decision notice (see OAR 461-001-0000) in public assistance and medical programs.

(b) The 90th day following the effective date of the reduction or termination of benefits in a public assistance program if the reduction or termination of aid is a result of a JOBS disqualification (see OAR 461-130-0330) or a penalty for failure to seek treatment for substance abuse or mental health (see OAR 461-135-0085).

(c) The 90th day following the date of the decision notice in the SNAP program, except:

(A) A filing group may submit a hearing request at any time within a certification period (see OAR 461-001-0000) to dispute its current level of benefits.

(B) A filing group may submit a hearing request within 90 days of the denial of a request for restoration of benefits if not more than twelve months has expired since the loss of benefits.

(d) The 30th day following the date of notice from the Oregon Department of Revenue in cases covered by ORS 293.250.

(e) In a case described in subsection (1)(h) of this rule, the request must be made within 90 days of the date the waiver was signed.

(7) When the Department receives a completed hearing request that is not filed within the timeframe required by section (6) of this rule but is filed no later than 120 days after a decision notice became a final order:

(a) The Department refers the hearing request to the Office of Administrative Hearings for a contested case hearing on the merits of the Department's action described in the notice:

(A) If the Department finds that the claimant and claimant's representative did not receive the decision notice and did not have actual knowledge of the notice; or

(B) If the Department finds that the claimant did not meet the timeframe required by section (6) of this rule due to excusable mistake, surprise, excusable neglect (which may include neglect due to significant cognitive or health issues), reasonable reliance on the statement of a Department employee relating to procedural requirements, or due to fraud, misrepresentation, or other misconduct of the Department.

(b) The Department may refer the request for a hearing to the Office of Administrative Hearings for a contested case proceeding to determine whether either of the following paragraphs apply.

(A) The claimant or claimant's representative received the decision notice or had actual knowledge of the decision notice. At the hearing, the

Department must show that the claimant or claimant's representative had actual knowledge of the notice or that the Department mailed the notice to the correct address of the claimant or claimant's representative, as provided to the Department.

(B) The claimant qualifies for a contested case hearing on the merits under paragraph (a)(B) of this section.

(c) The Department may dismiss a request for hearing as untimely if the claimant does not qualify for a hearing under subsection (a) of this section.

(8) In computing the time periods provided by this rule, see OAR 461-025-0300(1).

(9) In the REF and REFM programs, a client is not eligible for a contested case hearing when assistance is terminated because the eligibility time period imposed by OAR 461-135-0900 has been reached. If the issue is the date of entry into the United States the Department provides for prompt resolution of the issue by inspection of the individual's documentation issued by the US Citizenship and Immigration Services (USCIS) or by information obtained from USCIS, rather than by contested case hearing.

(10) If the Department receives a hearing request more than 120 days after a decision notice became a final order:

(a) For an overpayment notice:

(A) The Department verifies whether its records indicate that the liable adult requesting the hearing was sent the overpayment notice.

(B) If no overpayment notice was sent to that liable adult, the overpayment hearing request is timely. The Department will send the claimant a decision notice or a contested case notice.

(C) If the Department determines that an overpayment notice was sent to the liable adult, there is no hearing right based on the issue of whether or not the hearing request was received.

(b) Any hearing request is treated as timely when required under the Servicemembers Civil Relief Act.

(c) The Department may dismiss a request for hearing as untimely if the claimant does not qualify for a hearing under subsections (a) or (b) of this section.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 411.060, 411.095, 411.404, 411.408, 411.816, 411.892, 412.014, 412.049

Stats. Implemented: ORS 411.060, 411.095, 411.103, 411.117, 411.404, 411.408, 411.816, 411.892, 412.009, 412.014, 412.049, 412.069

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 4-1995, f. & ef. 2-1-95; AFS 26-1996, f. 6-27-96, cert. ef. 7-1-96; AFS 3-2000, f. 1-31-2000, cert. ef. 2-1-00; AFS 17-2000, f. 6-28-00, cert. ef. 7-1-00; AFS 25-2000, f. 9-29-00, cert. ef. 10-1-00; AFS 22-2001, f. & cert. ef. 10-1-01; AFS 23-2002(Temp), f. 12-31-02, cert. ef. 1-1-03 thru 6-30-03; SSP 16-2003, f. & cert. ef. 7-1-03; SSP 21-2004, f. & cert. ef. 10-1-04; SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; SSP 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 11-2007(Temp), f. & cert. ef. 10-1-07 thru 3-29-08; SSP 5-2008, f. 2-29-08, cert. ef. 3-1-08; SSP 8-2008, f. & cert. ef. 4-1-08; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 25-2011, f. 9-30-11, cert. ef. 10-1-11; SSP 4-2012(Temp), f. & cert. ef. 1-31-12 thru 7-29-12; SSP 25-2012, f. 6-29-12, cert. ef. 7-1-12; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-025-0315
Expedited Hearings

(1) A claimant has the right to an expedited hearing in each of the following situations:

(a) The Department denies or fails to issue a timely decision on claimant's request for:

(A) Emergency assistance; or

(B) TA-DVS (see OAR 461-135-1235).

(b) The claimant contests the form or amount of a TA-DVS or an emergency assistance payment.

(c) The claimant has the right to a hearing over a reduction, suspension, or closure and disagrees with the Department's decision to deny the continuation of one or more of the following pending a requested hearing:

(A) Cash benefits.

(B) Supplemental Nutrition Assistance Program benefits.

(C) Medical benefits.

(D) Nursing Home services or home and community-based care (see OAR 461-001-0030) that have been reduced or closed as a result of a service re-assessment conducted in accordance with OAR 411-015.

(d) The claimant's request for expedited SNAP service or DSNAP is denied, or the claimant is aggrieved by an action of the Department that affects the expedited participation of the household in the SNAP program.

(e) In the JOBS program, the Department denies an application for a support service payment or a payment for a basic living expense authorized by OAR 461-190-0211, or the Department reduces or closes a support service payment authorized by OAR 461-190-0211, or the Department does not issue a JOBS support service payment within the time frames required under OAR 461-115-0190.

(2) Public Assistance programs: An expedited hearing is a telephone hearing held within five working days of the Department's receipt of the written hearing request, unless the claimant requests more time. The claimant is entitled to reasonable notice of the hearing either through personal service, by overnight mail, or if the claimant agrees by electronic mail. The final order must be issued within three working days from the date the hearing closes.

(3) Supplemental Nutrition Assistance Program: An expedited hearing is a telephone hearing held within five working days of the receipt of a verbal or written hearing request, unless the claimant requests more time. The claimant is entitled to reasonable notice of the hearing either through personal service, by overnight mail, or if the claimant agrees by electronic mail. Following the expedited hearing, a final order must be issued not later than the ninth working day after the hearing was requested.

(4) If the Office of Administrative Hearings grants a face-to-face hearing, the hearing may be postponed or continued as necessary to accommodate the claimant. However, the hearing must be held not later than 21 days following the receipt by the Department of the request for hearing if the claimant lives within 100 miles of Salem, Oregon, and not later than 35 days in all other cases.

Stat. Auth.: ORS 411.060, 411.095, 411.404, 411.816, 412.049

Stats. Implemented: ORS 411.060, 411.095, 411.099, 411.103, 411.117, 411.404, 411.816, 412.049

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 21-1990(Temp), f. 8-28-90, cert. ef. 9-1-90; AFS 2-1991, f. 1-15-91, cert. ef. 2-1-91; AFS 4-1995, f. & ef. 2-1-95; AFS 9-1999, f. & cert. ef. 7-1-99; AFS 16-1999, f. 12-29-99, cert. ef. 1-1-00; AFS 10-2002, f. & cert. ef. 7-1-02; AFS 22-2002, f. 12-31-02, cert. ef. 1-1-03; AFS 23-2002(Temp), f. 12-31-02, cert. ef. 1-1-03 thru 6-30-03; SSP 16-2003, f. & cert. ef. 7-1-03; SSP 21-2004, f. & cert. ef. 10-1-04; SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; SSP 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 25-2012, f. 6-29-12, cert. ef. 7-1-12; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-110-0210
Household Group

(1) This rule describes who is included in the household group. The household group generally consists of the individuals who live together with or without the benefit of a dwelling. For homeless people, the household group consists of the individuals who consider themselves living together.

(2) A separate dwelling is not recognized for the purpose of determining the members of a household group unless the living space has, separate from any other dwelling, an access to the outside that does not pass through another dwelling, a functional sleeping area, bathroom, and kitchen facility.

(3) Each individual in the household group who applies for benefits is an applicant. The household group and applicants form the basis for determining who is in the remaining eligibility groups.

(4) For all programs except the SNAP program, a separate household group is established for individuals who live in the same dwelling as another household group, if all the following subsections are true:

(a) There is a landlord-tenant relationship between the two household groups in which the tenant is billed by the landlord at fair market value (see OAR 461-001-0000) for housing.

(b) The tenant lives independently from the landlord.

(c) The tenant:

(A) Has and uses sleeping, bathroom, and kitchen facilities separate from the landlord; or

(B) Shares bathroom or kitchen facilities with the landlord, but the facilities are in a commercial establishment that provides room or board or both for compensation at fair market value.

(5) Individuals who live with more than one household group during a calendar month are members of the household group in which they spend more than half of their time, except as follows:

(a) In the ERDC program, if a child (see OAR 461-001-0000) lives with different caretakers during the month, the child is considered a member of both household groups.

(b) In the MAA, MAF, and TANF programs:

(A) If a parent (see OAR 461-001-0000) sleeps at least 30 percent of the time during the calendar month in the home of the dependent child (see OAR 461-001-0000), the parent is in the same household group as the dependent child.

(B) A dependent child is included in the household group with the caretaker relative (see OAR 461-001-0000), who usually has the major responsibility for care and control of the dependent child, if the dependent child lives with two household groups in the same calendar month for at least one of the following reasons:

(i) Education.

(ii) The usual caretaker relative is gone from the household for part of the month because of illness.

(iii) A family emergency.

(c) In the SNAP program:

(A) The individual is a member of the household group that provides the individual more than half of his or her 21 weekly meals. If the individual is a child, the child is a member of the household group credited with providing the child more than half of his or her 21 weekly meals. A household group is credited with providing breakfast and lunch for each day the child departs that group's home for school, even if the child eats no breakfast or lunch at that home.

(B) During the month in which a resident of a domestic violence shelter (see OAR 461-001-0000) enters the domestic violence shelter, the resident may be included both in the household group he or she left and in a household group in the domestic violence shelter.

(6) In the OSIPM program, individuals receiving home and community-based care (see OAR 461-001-0030) or nursing facility care are each an individual household group.

(7) In the QMB program, the household group consists of the client and the client's spouse (see OAR 461-001-0000), even if the spouse does not meet all nonfinancial eligibility requirements.

(8) Individuals absent from the household for 30 days or more are no longer part of the household group, except for the following:

(a) In all programs except the SNAP program, an individual in an acute care medical facility remains in the household group unless the individual enters long-term care.

(b) In the CEC, CEM, ERDC, EXT, HKC, MAA, MAF, OHP, REF, REFM, SAC, and TANF programs:

(A) A caretaker relative who is absent for up to 90 days while in a residential alcohol or drug treatment facility is in the household group.

(B) A child who is absent for 30 days or more is in the household group if the child is:

(i) Absent for illness (unless the child is in a long-term care Title XIX facility), social service, or educational reasons;

(ii) In foster care, but expected to return to the household within the next 30 days; or

(iii) For the OHP program only, in a residential alcohol or drug treatment facility. If the household group of the child in a residential alcohol or drug treatment facility is ineligible because of income, the child is a separate household group.

(c) In the ERDC, HKC, and OHP programs, an individual in the household group who is absent because of education, training, or employment, including long-haul truck driving, fishing, or active duty in the U.S. armed forces.

(d) In the MAA, MAF, and REFM programs, in a two-parent household, a parent remains in the household group if the requirements of both of the following paragraphs are met:

(A) The parent is absent because of education, training or employment — including absence while working or looking for work outside the area of his or her residence, such as long-haul truck driving, fishing, or active duty in the U.S. armed forces; and

(B) The other parent remains in the home.

(e) In the REF and TANF programs when a filing group includes more than one caretaker relative (see OAR 461-001-0000), a caretaker relative in the household group who is absent because of education, training, or employment — including absence while working or looking for work outside the area of his or her residence, such as long-haul truck driving, fishing, or active duty in the U.S. armed forces.

(9) In the OSIP-EPD and OSIPM-EPD programs, the household group consists only of the individual applying for or receiving benefits.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.706, 411.816, 412.049, 414.231

Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.704, 411.706, 411.816, 412.001, 412.049, 414.025, 414.231, 414.826, 414.831, 414.839

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 13-1994, f. & cert. ef. 7-1-94; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 4-1998, f. 2-25-98, cert. ef. 3-1-98; AFS 1-1999(Temp), f. & cert. ef. 2-1-99 thru 7-31-99; AFS 3-1999, f. 3-31-99, cert. ef. 4-1-99; AFS 5-1999(Temp), f. & cert. ef. 4-1-99 thru 6-30-99; AFS 9-1999, f. & cert. ef. 7-1-99; AFS 17-2000, f. 6-28-00, cert. ef. 7-1-00; AFS 34-2000, f. 12-22-00, cert. ef. 1-1-01; AFS 19-2001, f. 8-31-01, cert. ef. 9-1-01; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 29-2009(Temp), f. & cert. ef. 10-1-09 thru 3-30-10; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 39-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SSP 18-2010, f. & cert. ef. 7-1-10; SSP 10-2011, f. 3-31-11, cert. ef. 4-1-11; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-135-0726

Specific Requirements; OSIP-IC and OSIPM-IC

To be eligible for OSIP-IC or OSIPM-IC, a person must meet criteria for In-Home Services and the Independent Choices program contained in OAR chapter 411, division 030.

Stat. Auth.: ORS 411.060

Stats. Implemented: ORS 411.060

Hist.: AFS 11-2001, f. 6-29-01, cert. ef. 7-1-01; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-135-0750

Eligibility for Individuals in Long-Term Care or Home and Community-Based Care; OSIPM

An individual who meets the requirements of all of the following sections is eligible for OSIPM:

(1) Meets the eligibility requirements for the OSIPM program except that income is above the OSIPM adjusted income standard for a one person need group (see OAR 461-155-0250(3)).

(2) Has countable income at or below 300 percent of the full SSI standard for a single individual; has established a qualifying trust as specified in OAR 461-145-0540(9)(c); or is eligible for the OSIPM-EPD program.

(3) Meets one of the following eligibility standards:

(a) The criteria in OAR 411-015-0100 (except subsection (1)(b)) regarding eligibility for nursing facility care or home and community-based care (see OAR 461-001-0030).

(b) The level-of-need criteria for an ICF/MR.

(c) The service eligibility standards for medically fragile children in OAR 411-350-0010.

(d) The service eligibility standards for the CIIS (Children's Intensive In-Home Services) behavioral program in OAR 411-300-0100 to 411-300-0220.

(e) The service eligibility standards for the Medically Involved Children's Waiver in OAR chapter 411, division 355.

(4) Resides in one of the following locations for a continuous period of care (see OAR 461-001-0030) and receives long-term care services (see OAR 461-180-0040 regarding the effective date for long-term care) authorized by the Department:

(a) A Medicaid-certified nursing facility.

(b) An intermediate care facility for the mentally retarded (ICF/MR).

(c) A psychiatric institution, if the individual is not yet 21 years of age or has reached the age of 65 or older.

(d) A home and community-based care setting.

(5) An individual in a home and community-based care setting must receive Title 1915(c) waivered services.

Stat. Auth.: ORS 411.060, 411.070, 411.404

Stats. Implemented: ORS 411.060, 411.070, 411.404

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 1-1999(Temp), f. & cert. ef. 2-1-99 thru 7-31-99; AFS 7-1999, f. 4-27-99, cert. ef. 5-1-99; AFS 11-2001, f. 6-29-01, cert. ef. 7-1-01; SSP 17-2004, f. & cert. ef. 7-1-04; SSP 19-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 10-2008(Temp), f. & cert. ef. 4-7-08 thru 9-30-08; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-135-0832

Estate Administration; Definitions

Effective July 18, 1995, for purposes of these rules (OAR 461-135-0832 to 461-135-0847) and ORS 93.268, 410.075, 411.694, 411.708, 411.795, 416.310, 416.340, and 416.350 the terms listed below have the meanings ascribed to them herein; provided, however, as used in these rules, any term has the same meaning as when used in a comparable context in the laws of the United States in effect on June 1, 1996, relating to the recovery of medical assistance paid by a state pursuant to 42 USC 1396 et. seq. relating to Grants to States for Medical Assistance Programs, unless a different meaning is clearly required or the term is specifically defined herein. The Department applies the definitions and procedures set forth in these rules to recoveries and claims made pursuant to ORS 411.708, 411.795, 416.310, 416.340, and 416.350.

(1) "Assets" means all income and resources of an individual, including any income or resources that an individual is entitled to at the time of death, including any income or resources to which the individual is entitled, but does not receive, because of action: by the individual; the individual's spouse; by a person, including a court or administrative body with legal authority to act in place of or on behalf of the individual; or by any person, including any court or administrative body, acting at the direction or upon the request of the individual.

(2) "Assign" means a person who acquires an interest in real or personal property or an asset pursuant to a written or oral assignment of such real or personal property or asset from a person with the legal right to assign it.

(3) "Blind child" means the deceased recipient's natural or adopted son or daughter, of any age, who, within two years after the Department initially asserts its claim, substantiates blindness throughout the time the Department seeks to enforce its claim by presenting evidence of:

(a) Vision of 20/200 or less in the better eye with a corrective lens; or

(b) A limitation in vision field to an angle of 20 degrees or less; or

(c) Meeting any other SSI criteria for blindness.

(4) "Bona fide purchaser for value" means any person who provides consideration, including money or property, to a seller or transferor of real property or personal property equal to the fair market value of the real or personal property sold or transferred.

(5) "Child under age 21" means the deceased recipient's natural or adopted son or daughter who is under 21 years of age throughout the time the Department seeks to enforce its claim.

(6) "Consideration furnished test" means the method by which the ownership of real or personal property is traced to its economic origin. The fractional share of the property considered owned by a co-owner shall be that fractional share to have originally belonged to or to be attributable to the monetary consideration furnished by the co-owner. The fractional share is based on the proportion the original ownership share or monetary consideration bore to the acquisition cost and, if applicable, capital additions for the property. The fractional share is not based on the dollar amount of contribution compared to the current market value of the property. For example, if one co-owner contributed $2,500 and the other $7,500 to the purchase price of a $10,000 property in 1960; in 1995, the property is appraised at $50,000. The co-owner who contributed $2,500 is considered to own 25% of the property in 1995.

(7) "Convincing evidence" includes, but is not limited to:

(a) Recorded documents of title.

(b) Unrecorded documents of title executed contemporaneously with the transaction or transfer at issue.

(c) Tax statements or returns.

(d) Records of banking, financial or other similar institutions.

(e) Written receipts, bills of sale or other writings or documents executed contemporaneously with the transaction or transfer at issue.

(f) Such other reliable, probative evidence, including oral, of a similar nature and authenticity that accurately reflects the true facts of the transaction or transfer at issue.

(8) "Date of request" means the date an individual or someone authorized on behalf of the individual contacts the Department or uses another appropriate method to request benefits (see OAR 461-115-0150). The request may be oral or in writing. It starts the application process.

(9) "Disabled child" means the deceased recipient's natural or adopted son or daughter of any age, who meets SSI disability criteria throughout the time the Department seeks to enforce its claim, and who presents evidence to the Department substantiating the disability within two years after the Department initially asserts its claim.

(10) "Estate" means:

(a) With respect to the collection of payments made for public assistance provided prior to July 18, 1995, or for exclusively state funded public assistance, all real property, personal property, or other assets included within a recipient's estate, or the estate of the recipient's spouse, as such estate is defined by applicable state probate law.

(b) With respect to the collection of payments made for public assistance provided on or after July 18, 1995:

(A) For recipients who die prior to October 1, 2008, all real property, personal property, or other assets, wherever located, in which a recipient had any legal title or ownership or beneficial interest at the time of death, including real property, personal property, or other assets conveyed by the recipient to, subsequently acquired by, or traceable to, a person, including the recipient's surviving spouse and any successor-in-interest to the recipient's surviving spouse, through:

(i) Tenancy by the entirety;

(ii) Joint tenancy;

(iii) Tenancy in common;

(iv) Not as tenants in common, but with the right of survivorship;

(v) Life estate;

(vi) Transfer on death deed;

(vii) Living trust;

(viii) Annuity purchased on or after April 1, 2001; or

(ix) Other similar arrangement.

(B) For recipients who die on or after October 1, 2008, all real property, personal property, or other assets, wherever located, in which a recipient had any legal title or ownership or beneficial interest at the time of death of the recipient, including real property, personal property, or other assets conveyed by the recipient to, subsequently acquired by, or traceable to, a person, including the recipient's spouse and any successor-in-interest to the recipient's spouse, through:

(i) Tenancy by the entirety;

(ii) Joint tenancy;

(iii) Tenancy in common;

(iv) Not as tenants in common, but with the right of survivorship;

(v) Life estate;

(vi) Transfer on death deed;

(vii) Living trust;

(viii) Annuity purchased on or after April 1, 2001; or

(ix) Other similar arrangement, such as an interspousal transfer of assets, including one facilitated by a court order, which occurred no earlier than 60 months prior to the first date of request established from the recipient's and the recipient's spouse's applications, or at any time thereafter, whether approved, withdrawn, or denied, for the public assistance programs referenced in OAR 461-135-0835(2).

(11) "Heir" means any individual, including the surviving spouse, who is entitled under intestate succession to the real property, personal property, and assets of a decedent who died wholly or partially intestate.

(12) "Interest" means any form of legal, beneficial, equitable or ownership interest.

(13) "Interspousal transfer" means any transfer, or chain of transfers, that effectively transfers title or control of an asset, or an interest in an asset, from one spouse to another, including: direct transfers between spouses, transfers from one or both spouses to a trust, and transfers from one trust to another trust.

(14) "Intestate" means one who dies without leaving a valid will, or the circumstance of dying without leaving a valid will, effectively disposing of all of a decedent's estate.

(15) "Intestate succession" means succession to real property, personal property or assets of a decedent who dies intestate or partially intestate.

(16) "Joint tenancy" means ownership of property held under circumstances that entitle one or more owners to the whole of the property on the death of the other owner(s), including, but not limited to, joint tenants with right of survivorship and tenants by the entirety.

(17) "Legal title" means legal ownership by a person.

(18) "Life estate" means an interest in real or personal property that terminates upon the death of a measuring life.

(19) "Living trust" means a revocable or irrevocable inter vivos trust funded with assets to which the recipient is legally entitled.

(20) "Medical institution" means a facility that provides care and services equivalent to those received in a nursing facility. Medical Institution does not apply to home and community-based care (see OAR 461-001-0030) in-home services, adult foster home (AFH) care, residential care facility (RCF) services, or assisted living facility (ALF) care.

(21) "Ownership documents" mean any applicable documents, certificates or written evidence of title or ownership such as, but not limited to, recorded deeds, stock certificates, certificates of title, bills of sale or other similar documents evidencing ownership or legal title held by a person.

(22) "Permanently institutionalized" means an individual, regardless of age, who, at the time of his or her death, had resided in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, for 180 days or more.

(23) "Person" means any individual, corporation, association, firm, partnership, trust, estate or other form of entity.

(24) "Personal property" means all tangible and intangible personal property wherever located, including, but not limited to, chattels and movables, boats, vehicles, furniture, personal effects, livestock, tools, farming implements, cash, currency, negotiable papers, securities, contracts, and contract rights.

(25) "Real property" means all land wherever situated, including improvements and fixtures thereon, and every estate, Interest, and right, whether legal or equitable, therein including, but not limited to, fee simple, terms for years, life estates, leasehold interests, condominiums or time share properties. Real property includes property conveyed by the individual to, subsequently acquired by, or traceable to, a person, including the individual's surviving spouse and any successor-in-interest to the individual's surviving spouse, if the real property may be included in the individual's, or the individual's surviving spouse's, estate, as defined in this rule.

(26) "Recipient of property" means:

(a) Any survivor, heir, assign, devisee under a will, beneficiary of a trust, transferee or other person to whom real property, personal property or other assets pass upon the death of the decedent either by law, intestate succession, contract, will, trust instrument or otherwise; and

(b) Any subsequent transferee of such real property, personal property, or asset, or proceeds from the sale thereof, through any form of conveyance, that is not a bona fide purchaser for value.

(27) "Survivor" means any person who, as a co-tenant, is automatically entitled to an expanded share of real or personal property upon the death of a fellow co-tenant.

(28) "Survivorship" means an interest in real or personal property that expires upon the death of an individual whereby the Interest of the individual's co-owners automatically expands to the same extent without necessity for any act of transfer or distribution.

(29) "Tenancy in common" means ownership of real or personal property by an individual together with one or more other persons which ownership interest shall not pass by survivorship upon the death of the individual.

(30) "Time of death" means the instant of death, the time and date of which shall be established in the place of the decedent's residence; in no case shall time of death be construed to mean a time after which an interest in real or personal property or other assets may:

(a) Pass by survivorship or other operation of law due to the death of the decedent; or

(b) Terminate by reason of the decedent's death.

(31) "Transfer on death deed" has the meaning set out in Oregon Laws 2011, chapter 212, section 2.

(32) "Value" means the fair market value. Fair market value is the price at which real or personal property would change hands between a willing buyer and a willing seller. In the event the real or personal property was not reported to the Department by the deceased Medicaid recipient, the value would be established based on its fair market value at the time of discovery.

Stat. Auth: ORS 93.268, 410.070, 410.075, 411.060, 411.070, 416.340, 416.350
Stats. Implemented: ORS 93.268, 410.070, 410.075, 411.010, 411.060, 411.694, 411.708, 411.795, 416.310, 416.340, 416.350, 2011 OL 212 sec. 2, 2011 OL 720 sec. 224
Hist.: AFS 29-1996, f. & cert. ef. 8-28-96; AFS 30-2000, f. & cert. ef. 12-1-00; AFS 6-2001, f. 3-30-01, cert. ef. 4-1-01; AFS 22-2001, f. & cert. ef. 10-1-01; AFS 5-2002, f. & cert. ef. 4-1-02; AFS 10-2002, f. & cert. ef. 7-1-02; SSP 16-2003, f. & cert. ef. 7-1-03; SSP 33-2003, f. 12-31-03, cert. ef. 1-4-04; SSP 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 6-2006, f. 3-31-06, cert. ef. 4-1-06; SSP 16-2008, f. 7-1-08, cert. ef. 10-1-08; SSP 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 5-2010, f. & cert. ef. 4-1-10; SSP 35-2011, f. 12-27-11, cert. ef. 1-1-12; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-135-0835
Limits on Estate Claims

(1) In the BCCM, GA, GAM, OHP, OSIP, OSIPM, and QMB programs:

(a) The Department has a priority claim against the property or any interest therein belonging to the estate of any deceased person as provided in ORS Chapters 411 and 416. The Estate Administration Unit of the Department (EAU) is authorized to present and file such claim against the estate. It will be treated as a preferred claim and filed in a like manner as the claims of other creditors.

(b) In determining the extent of the estate resources subject to the Department's claim, except as provided in subsection (c) of this section, the Department must disregard resources in an amount equal to the value of resources excluded in the most recent eligibility determination under OAR 461-160-0855, based on payments received under a qualified partnership policy (see OAR 461-001-0000). The disregard of resources specific to the estate recovery claim applies to Medicaid benefits received after the effective date of the Medicaid eligibility determination in which a qualified partnership policy was considered and approved. The amount of any Medicaid assistance incurred in a prior Medicaid eligibility period where qualified partnership policy benefits were not considered would not be subject to the estate resource disregard.

(c) There is no disregard of resources under subsection (b) of this section if the client, or the spouse of the client, at any time transferred the value of the qualified partnership policy excluded resource amount to another individual for less than fair market value prior to the death of the client or the client's surviving spouse, or exhausted the disregarded resource amount by purchasing things of value to the client or the client's surviving spouse while either was living.

(d) For a recipient who died prior to October 1, 2008:

(A) If there is a surviving spouse, the Department has a claim against the estate of the surviving spouse for public assistance paid to the surviving spouse.

(B) In addition, the Department has a claim against the estate of the surviving spouse for public assistance paid to the pre-deceased spouse, but only to the extent that the surviving spouse received property or other assets from the pre-deceased spouse through any of the following:

(i) Probate.

(ii) Operation of law.

(C) If estate recovery is deferred until the surviving spouse dies, the fair market value of the property subject to the Department's claim is determined based on the current value (see OAR 461-135-0832) of the property in the surviving spouse's estate.

(D) However, neither claim is enforceable until after the death of the surviving spouse (if any) and only when there is no surviving child under age 21 (see OAR 461-135-0832), no surviving blind child (see OAR 461-135-0832) of any age, and no surviving disabled child (see OAR 461-135-0832) of any age.

(e) For a recipient who died on or after October 1, 2008:

(A) If there is a surviving spouse, the Department has a claim against the estate of the surviving spouse for public assistance paid to the surviving spouse.

(B) In addition, the Department has a claim against the estate of the recipient's spouse for public assistance paid to the recipient, but only to the extent that the recipient's spouse received property or other assets from the recipient through any of the following:

(i) Probate.

(ii) Operation of law.

(iii) An interspousal transfer, including one facilitated by a court order, which occurs:

(I) Before, on, or after October 1, 2008; and

(II) No earlier than 60 months prior to the first date of request (see OAR 461-135-0832) established from the applications of the recipient and the recipient's spouse, or at any time thereafter, whether approved, withdrawn, or denied, for the public assistance programs referenced in section (2) of this rule.

(C) If estate recovery is deferred until the recipient's spouse dies, the fair market value of the property subject to the Department's claim is determined based on the current value of the property in the estate of the recipient's spouse.

(D) However, neither claim is enforceable until after the death of the recipient's spouse (if any) and only when there is no surviving child under age 21, no surviving blind child of any age, and no surviving disabled child of any age.

(E) The October 1, 2010 amendment to paragraph (B) of this subsection applies to claims asserted on or after April 1, 2010.

(2) The amount of the claim is as follows:

(a) Any payments made at any age under the General Assistance provisions of ORS Chapter 411, categorized as GA, are recoverable from the estate of any deceased recipient or the estate of the recipient's spouse. In the GA and GAM programs, the amount of the claim will not exceed the total amount of cash and medical benefits paid. The claim will include home and community-based care (see OAR 461-001-0030) benefits. This applies to all General Assistance programs, even those that are no longer active.

(b) In the BCCM, OSIP AD, OSIP OAA, OSIPM AD, OSIPM OAA, and QMB programs, the amount of the claim includes all GA category benefits paid at any age and all Title XIX benefits provided after the recipient reached age 55, except any QMB program payment. If the recipient was permanently institutionalized (see OAR 461-135-0832), the claim includes the total amount of all GA category benefits and Title XIX benefits paid at any age. This applies to all Old Age Assistance and Aid to the Disabled recipients, including recipients of home and community-based care. It also includes recipients covered by programs that are no longer active.

(c) In the OHP, OSIP AB, and OSIPM AB programs, the claim includes the total amount of GA category benefits paid at any age and all Title XIX benefits provided after the recipient reached age 55. If the recipient was permanently institutionalized, the claim includes the total amount of GA category and Title XIX benefits paid at any age. The claim includes home and community-based care benefits.

(d) In the OSIP, OSIPM-AB, OSIPM AD, and OSIPM-OAA programs, the amount of the claim also includes the total amount of GA category and Title XIX benefits provided to recipients who were age 55 to 64 on the date the GA category and Title XIX benefits were provided if the benefits were provided after July 18, 1995. GA category and Title XIX benefits will be considered to have been provided to a recipient on the day of provision of medical services for which medical assistance payments are made.

(3) The priority for payment of claims against the estate will be as established under ORS 115.125.

(4) EAU may nominate a personal representative for an estate if the Department has a claim and it appears that no person with a higher preference, as established in ORS 113.085, is willing to be the representative.

(5) Property disposal will be in accordance with OAR 461-135-0838.

Stat. Auth.: ORS 410.070, 411.060 & 416.350
Stats. Implemented: ORS 410.070, 411.060, 411.708, 411.795, 416.310, 416.340, 416.350

Hist.: AFS 13-1991, f. & cert. ef. 7-1-91; AFS 41-1995, f. 12-26-95, cert. ef. 1-1-96; AFS 24-1997, f. 12-31-97, cert. ef. 1-1-98; AFS 5-2002, f. & cert. ef. 4-1-02; AFS 10-2002, f. & cert. ef. 7-1-02; AFS 13-2002, f. & cert. ef. 10-1-02; SSP 16-2003, f. & cert. ef. 7-1-03; SSP 6-2006, f. 3-31-06, cert. ef. 4-1-06; SSP 14-2007, f. 12-31-07, cert. ef. 1-1-08; SSP 16-2008, f. 7-1-08, cert. ef. 10-1-08; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 5-2010, f. & cert. ef. 4-1-10; SSP 16-2010(Temp), f. & cert. ef. 5-27-10 thru 11-23-10; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-140-0296
Length of Disqualification Due to An Asset Transfer; GA, GAM, OSIP, OSIPM

(1) This rule applies to clients in the GA, GAM, OSIP, and OSIPM programs who live in a nonstandard living arrangement (see OAR 461-001-0000).

(2) A financial group containing a member disqualified due to the transfer of an asset is disqualified from receiving benefits. The length of a disqualification period resulting from the transfer is the number of months equal to the uncompensated value (see OAR 461-140-0250) for the transfer divided by the following dollar amount:

(a) If the initial month (see OAR 461-001-0000) is prior to October 1, 1998 — $2,595.

(b) If the initial month is on or after October 1, 1998 and prior to October 1, 2000 — $3,320.

(c) If the initial month is on or after October 1, 2000 and prior to October 1, 2002 — $3,750.

(d) If the initial month is on or after October 1, 2002 and prior to October 1, 2004 — $4,300.

(e) If the initial month is on or after October 1, 2004 and prior to October 1, 2006 — $4,700.

(f) If the initial month is on or after October 1, 2006 and prior to October 1, 2008 — $5,360.

(g) If the initial month is on or after October 1, 2008 and prior to October 1, 2010 — $6,494.

(h) If the initial month is on or after October 1, 2010 — $7,663.

(3) For transfers by a client and the spouse of a client that occurred before July 1, 2006:

(a) Add together the uncompensated value of all transfers made in one calendar month, and treat this total as one transfer.

(b) If the uncompensated value of the transfer is less than the applicable dollar amount identified in subsections (2)(a) to (2)(h) of this rule, there is no disqualification.

(c) If there are multiple transfers in amounts equal to or greater than the applicable dollar amount identified in subsections (2)(a) to (2)(h) of this rule, each disqualification period is calculated separately.

(d) The number of months resulting from the calculation in section (2) of this rule is rounded down to the next whole number.

(e) Except as provided in subsection (3)(f) of this rule, the first month of the disqualification is the month the asset was transferred.

(f) If disqualification periods calculated in accordance with this rule overlap, the periods are applied sequentially so that no two penalty periods overlap.

(g) If both spouses of a couple are in a nonstandard living arrangement and made the disqualifying transfer, part of the disqualification is apportioned to each of them, based on their percentage of ownership in the transferred asset. If one spouse is unable to serve the resulting disqualification period for any reason, the remaining disqualification applicable to both spouses must be served by the remaining spouse.

(4) For transfers by a client and the spouse of a client that occurred on or after July 1, 2006 and for income cap trusts under OAR 461-145-0540(9)(c) that accumulate funds in excess of the applicable dollar amount identified in subsections (2)(a) to (2)(h) of this rule:

(a) If there are multiple transfers by the client and the spouse of the client, including any transfer less than the applicable dollar amount identified in subsections (2)(a) to (2)(h) of this rule, the value of all transfers are added together before dividing by the applicable dollar amount identified in subsections (2)(a) to (2)(h) of this rule. For an income cap trust, the calculation in section (2) of this rule is performed as soon as, but not before, funds have accumulated to at least the applicable dollar amount identified in subsections (2)(a) to (2)(h) of this rule.

(b) The quotient resulting from the calculation in section (2) of this rule is not rounded. The whole number of the quotient is the number of full months the financial group is disqualified. The remaining decimal or fraction of the quotient is used to calculate an additional partial month disqualification. This remaining decimal or fraction is converted to an additional number of days by multiplying the decimal or fraction by the number of days in the month following the last full month of the disqualification period. If this calculation results in a fraction of a day, the fraction of a day is rounded down.

(c) Notwithstanding when the Department learns of a disqualifying transfer, the first month of the disqualification is:

(A) For a client who transfers an asset while he or she is already receiving Department-paid long-term care (see OAR 461-001-0000) or home and community-based care (see OAR 461-001-0030) in a nonstandard living arrangement, the month following the month the asset was transferred, except that if disqualification periods calculated in accordance with this rule overlap, the periods are applied sequentially so that no two penalty periods overlap.

(B) For an applicant who transfers an asset prior to submitting an application and being determined eligible and for a client who transfers an asset while he or she is already receiving benefits in a standard living arrangement (see OAR 461-001-0000), the date of request (see OAR 461-115-0030) for long-term care or home and community-based care as long as the applicant or client would otherwise be eligible but for this disqualification period. If the applicant or client is not otherwise eligible on the date of request, the disqualification begins the first date following the date of request that the applicant or client would be otherwise eligible but for the disqualification period.

(d) If both spouses of a couple are in a nonstandard living arrangement and made the disqualifying transfer, part of the disqualification is apportioned to each of them, based on their percentage of ownership in the transferred asset. If one spouse is unable to serve the resulting disqualification period, the remaining disqualification applicable to both spouses must be served by the remaining spouse.

(5) If an asset is owned by more than one person, by joint tenancy, tenancy in common, or similar arrangement, the share of the asset owned by the client is considered transferred when any action is taken either by the client or any other person that reduces or eliminates the client's control or ownership in the client's share of the asset.

(6) For an annuity that is a disqualifying transfer under section (11) of OAR 461-145-0022, the disqualification period is calculated based on the uncompensated value as calculated under OAR 461-140-0250, unless the only requirement that is not met is that the annuity pays beyond the actuarial life expectancy of the annuitant. If the annuity pays beyond the actuarial life expectancy of the annuitant, the disqualification is calculated according to section (7) of this rule.

(7) If a client or the spouse of a client purchases an annuity on or before December 31, 2005 and the annuity pays benefits beyond the actuarial life expectancy of the annuitant, as determined by the Period Life Table of the Office of the Chief Actuary of the Social Security Administration, a disqualification period is assessed for the value of the annuity beyond the actuarial life expectancy of the annuitant.

(8) A single transfer of an asset may cause a disqualification for both a medical assistance program under this rule and the SSI cash grant. The period of the disqualification is likely to be longer for SSI than for the medical assistance program, so a person may be eligible again for the medical assistance program while still disqualified from receiving SSI. The provisions of this rule are applied without regard to the related disqualification for SSI.

Stat. Auth.: ORS 411.060, 411.704, 411.706
Stats. Implemented: ORS 411.060, 411.704, 411.706
Hist.: AFS 17-1998, f. & cert. ef. 10-1-98; AFS 10-2000, f. 3-31-00, cert. ef. 4-1-00; AFS 26-2000, f. & cert. ef 10-4-00; AFS 6-2001, f. 3-30-01, cert. ef. 4-1-01; AFS 13-2002, f. & cert. ef. 10-1-02; SSP 23-2003, f. & cert. ef. 10-1-03; SSP 22-2004, f. & cert. ef. 10-1-04; SSP 19-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; SSP 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-145-0540
Trusts

(1) This section applies to all trust funds (see OAR 461-001-0000) in the MAA, MAF, OHP, REF, REFM, SAC, SNAP, and TANF programs. It also applies to GA, GAM, OSIP, OSIPM, and QMB for trust funds established before October 1, 1993:

(a) Trust funds are counted as a resource if the fund is legally available for use by a member of the financial group (see OAR 461-110-0530) for items covered by program benefits. In the OSIP, OSIPM, and QMB programs, the amount of the trust that is considered legally available is the maximum amount that could be distributed to the beneficiary under the terms of the trust, regardless of whether the trustee exercises his or her authority to actually make a distribution.

(b) Trust funds are excluded if the fund is not available for use by a member of the financial group. The financial group must try to remove

legal restrictions on the trust, unless that would cause an expense to the group.

(c) The part of the fund available for use for medical expenses covered by the medical program for which the financial group is eligible is counted.

(2) In the ERDC program, all trust funds are excluded.

(3) In the OSIP, OSIPM, and QMB programs, trust funds established on or after October 1, 1993, are treated in accordance with sections (4) to (10) of this rule. In the GA and GAM programs, trust funds established on or after October 1, 1993, are treated in accordance with sections (4) to (8) of this rule.

(4) A trust is considered established if the financial group used their resources to form all or part of the trust and if any of the following established a trust, other than by a will:

(a) The client.

(b) The client's spouse.

(c) Any other person, including a court or administrative body, with legal authority to act in place of or on behalf of the client or the client's spouse.

(d) Any other person, including a court or administrative body, acting at the direction or upon the request of the client or the client's spouse.

(5) If the trust contains resources or income of another person, only the share attributable to the client is considered available.

(6) Except as provided in section (9) of this rule, the following factors are ignored when determining how to treat a trust:

(a) The purpose for which the trust was established.

(b) Whether or not the trustees have or exercise any discretion under the trust.

(c) Any restrictions on when or if distributions may be made from the trust.

(d) Any restrictions on the use of distributions from the trust.

(7) If the trust is revocable, it is treated as follows:

(a) The total value of the trust is considered a resource available to the client.

(b) A payment made from the trust to or for the benefit of the client is considered unearned income.

(c) A payment from the trust other than to or for the benefit of the client is considered a transfer of assets covered by OAR 461-140-0210 and following.

(8) If the trust is irrevocable, it is treated as follows:

(a) If, under any circumstances, the funds transferred into the trust are unavailable to the client and the trustee has no discretion to distribute the funds to or for the benefit of the client, the client is subject to a transfer-of-resources penalty as provided in OAR 461-140-0210 and following.

(b) If, under any circumstances, payments could be made to or on behalf of the client, the share of the trust from which the payment could be made is considered a resource. A payment from the trust other than one to or for the benefit of the client is considered a transfer of assets that may be covered by OAR 461-140-0210.

(c) If, under any circumstances, income is generated by the trust and could be paid to the client, the income is unearned income. Payments made for any reason other than to or for the benefit of the client are considered a transfer of assets subject to disqualification per OAR 461-140-0210.

(d) If any change in circumstance makes assets (income or resources) from the trust unavailable to the client, the change is a disqualifying transfer as of the date of the change.

(9) Notwithstanding the provisions in sections (1) and (3) to (8) of this rule, the following trusts are not considered in determining eligibility for OSIPM and QMB:

(a) A trust containing the assets of a client determined to have a disability that meets the SSI criteria that was created before the client reached age 65, if the trust was established by one of the following and the state will receive all funds remaining in the trust upon the death of the client, up to the amount of medical benefits provided on behalf of the client:

(A) The client's parent.

(B) The client's grandparent.

(C) The client's legal guardian or conservator.

(D) A court.

(b) A trust established between October 1, 1993 and March 31, 1995 for the benefit of the client and containing only the current and accumulated income of the client. The accumulated amount remaining in the trust must be paid directly to the state upon the death of the client up to the amount of medical benefits provided on behalf of the client. The trust is the total income in excess of the income standard for OSIPM. The remaining income not deposited into the trust is available for the following deductions in the order they appear prior to applying the patient liability:

(A) Personal-needs allowance.

(B) Community spouse monthly maintenance needs allowance.

(C) Medicare and other private medical insurance premiums.

(D) Other incurred medical.

(c) A trust established on or after April 1, 1995 for the benefit of the client whose income is above 300 percent of the full SSI standard and containing the current and accumulated income of the client. The accumulated amount remaining in the trust must be paid directly to the state upon the death of the client up to the amount of medical assistance provided on behalf of the client. The trust contains all of the client's income. The income deposited into the trust is distributed monthly in the following order with excess amounts treated as income to the individual subject to the rules on transfer of assets in division 140 of this chapter of rules:

(A) Personal needs allowance and applicable room and board standard.

(B) Reasonable administrative costs of the trust, not to exceed a total of $50 per month, including the following:

(i) Trustee fees.

(ii) A reserve for administrative fees and costs of the trust, including bank service charges, copy charges, postage, accounting and tax preparation fees, future legal expenses, and income taxes attributable to trust income.

(iii) Conservatorship and guardianship fees and costs.

(C) Community spouse and family monthly maintenance needs allowance.

(D) Medicare and other private medical insurance premiums.

(E) Other incurred medical costs as allowed under OAR 461-160-0030 and 461-160-0055.

(F) Contributions to reserves or payments for child support, alimony, and income taxes.

(G) Monthly contributions to reserves or payments for the purchase of an irrevocable burial plan with a maximum value of $5,000.

(H) Contributions to a reserve or payments for home maintenance if the client meets the criteria of OAR 461-155-0660 or OAR 461-160-0630.

(I) Patient liability not to exceed the cost of home and community-based care (see OAR 461-001-0030) or nursing facility services.

(10) This section of the rule applies to a trust signed on or after July 1, 2006.

(a) Notwithstanding the provisions of sections (1) and (3) to (8) of this rule, a trust that meets the requirements of subsection (b) of this section is not considered in determining eligibility for OSIPM and QMB, except that if the client is age 65 or older when the trust is funded or a transfer is made to the trust, the transfer may constitute a disqualifying transfer of assets under OAR 461-140-0210 and following.

(b) This section of the rule applies to a trust that meets all of the following conditions:

(A) The trust is established and managed by a non-profit association.

(B) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(C) The trust is established by the client, client's parent, grandparent, or legal guardian or a court for clients who have disabilities.

(D) Upon the death of the beneficiary or termination of the trust, the trust pays to the State an amount equal to the total medical assistance paid on behalf of the beneficiary under the State plan for Medicaid. The amount paid to the state may be reduced by administrative costs directly related to administering the sub-trust account of the beneficiary.

(E) The trust contains the resources or income of a client who has a disability that meets the SSI criteria.

(11) In the GA, GAM, OSIP, OSIPM, and QMB programs, the provisions of this rule may be waived for an irrevocable trust if the Department determines that denial of benefits would create an undue hardship on the client if, among other things:

(a) The absence of the services requested may result in a life-threatening situation.

(b) The client was a victim of fraud or misrepresentation.

Stat. Auth: ORS 411.060, 411.070, 411.700, 411.816, 412.049, 414.042

Stats. Implemented: ORS 411.060, 411.070, 411.700, 411.816, 412.049, 414.042

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 18-1993(Temp), f. & cert. ef. 10-1-93; AFS 29-1993, f. 12-30-93, cert. ef. 1-1-94; AFS 6-1994, f. & cert. ef. 4-1-94; AFS 13-1994, f. & cert. ef. 7-1-94; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 13-1995, f. 6-29-95, cert. ef. 7-1-95; AFS 21-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 13-1997, f. 8-28-97, cert. ef. 9-1-97; AFS 25-2000, f. 9-29-00, cert. ef. 10-1-00; AFS 34-2000, f. 12-22-00, cert. ef. 1-1-01; AFS 6-2001, f. 3-30-01, cert. ef. 4-1-01; AFS 22-2001, f. & cert. ef. 10-1-01; AFS 5-2002, f. & cert. ef. 4-1-02; AFS 18-2002(Temp), f. & cert. ef, 11-19-02 thru 5-18-03; SSP 11-2003, f. & cert. ef. 5-1-03; SSP 16-2003, f. & cert. ef. 7-1-03; SSP 22-2004, f. & cert. ef. 10-1-04;

SSP 19-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 16-2006(Temp), f. 12-29-06, cert. ef. 1-1-07 thru 3-31-07; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-145-0580
Veterans' Benefits

(1) Veterans' benefits, other than the educational and training and rehabilitation program benefits, are treated as follows:

(a) Except as specified in sections (2) and (5) of this rule, monthly payments are counted as unearned income.

(b) Other payments are counted as periodic or lump sum income (see OAR 461-140-0110 and 461-140-0120).

(2) Veterans' benefits that include aid-and-attendance payments are treated as follows:

(a) For OSIP and OSIPM clients receiving long term care or home and community-based care (see OAR 461-001-0030):

(A) When determining eligibility, the entire veterans' benefit payment is excluded.

(B) When calculating monthly benefits or patient liability, the entire veterans' benefit payment is counted as unearned income.

(C) Payments for services not covered by the Department's programs are excluded.

(D) If the client receives a payment covering a previous period of eligibility, the client is required to turn over to the Department the full amount of the payment up to the cost of institutional and home and community-based care provided to the client during the months covered by the payment. A client's failure to reimburse the Department in this instance constitutes an overpayment of public assistance in accordance with OAR 461-195-0501 and 461-195-0521 and ORS 411.640 and 411.690. Any excess veterans' benefit payment made to the client is counted as lump sum or periodic income.

(b) For all other clients not covered under subsection (a) of this section:

(A) In the SNAP program, aid-and-attendance payments used to pay for an attendant are treated as a reimbursement and excluded (see OAR 461-145-0440). The remaining benefits, if any, are counted as unearned income.

(B) In the OHP and QMB programs, the aid-and-attendance payments are excluded. The remaining benefits are counted unless excluded under another rule or another section of this rule.

(C) Reimbursements paid to the client for costs and services already paid for by the Department are third-party resources and may be recovered from the client as an overpayment of public assistance pursuant to OAR 461-195-0501, 461-195-0521, and 461-195-0551. Any unrecovered third-party resource or payment above the actual cost is counted as lump-sum or periodic income (see OAR 461-140-0110 and 461-140-0120).

(3) Educational benefits from the United States Veterans Administration are treated in accordance with OAR 461-145-0150.

(4) A subsistence allowance from a training and rehabilitation program of the United States Veterans Administration is treated:

(a) In the SNAP program, as earned income (see OAR 461-145-0130).

(b) In all other programs, as unearned income.

(5) The following payments are excluded:

(a) Payments under 38 USC 1805 to biological children of Vietnam veterans who are born with spina bifida.

(b) Payments under 38 USC 1815 to children with birth defects born to female Vietnam veterans.

Stat. Auth.: ORS 411.060, 411.404, 411.816, 412.014, 412.049
Stats. Implemented: ORS 411.060, 411.404, 411.620, 411.640, 411.690, 411.700, 411.816, 412.014, 412.049
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 30-1990, f. 12-31-90, cert. ef. 1-1-91; AFS 2-1994, f. & cert. ef. 2-1-94; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 19-1997, f. & cert. ef. 10-1-97; AFS 25-2000, f. 9-29-00, cert. ef. 10-1-00; AFS 5-2002, f. & cert. ef. 4-1-02; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 19-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 14-2007, f. 12-31-07, cert. ef. 1-1-08; SSP 5-2009, f. & cert. ef. 4-1-09; SSP 26-2012(Temp), f. & cert. ef. 7-11-12 thru 1-7-13; SSP 37-2012, f. 12-28-12, cert. ef. 1-1-13; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-155-0020
Prorated Standards; Adjusted Number in Household

(1) Prorated standards are used only in the no-adult tables and the non-SSI OSIP and OSIPM table.

(2) In the OSIP and OSIPM programs:

(a) Prorated standards only apply when an individual or a couple receives free food and shelter from others living in the household, and the individual or couple does not have an ownership interest or rental liability in the residence.

(b) Prorated standards are not applied to cases in which a client receives services described in OAR chapter 411, division 015.

(c) Shelter-in-kind (see OAR 461-145-0470) may apply when prorated standards are not used.

(3) In the TANF program, the no-adult tables are used when there are no adults in TANF need group (see OAR 461-110-0630).

(4) Prorated standards are based on the number of people in the need group, compared to the adjusted number in the household group (see OAR 461-110-0210). The adjusted number in the household is determined by taking the total number of individuals in the household, minus the following individuals unless they are included in the need group:

(a) Unborns.

(b) Clients receiving long-term care or home and community-based care (see OAR 461-001-0030).

(c) Foster children.

(d) Children receiving adoption assistance.

(e) Live-in attendants who live with the filing group solely to provide necessary medical or housekeeping services and are paid to provide these services.

(f) Landlords and tenants. A landlord-tenant relationship exists if one person pays another at fair market value for housing and if:

(A) The filing group lives independently from the landlord or tenant;

(B) The filing group has and uses sleeping, bathroom, and kitchen facilities that are separate from the landlord or tenant; and

(C) If bathroom or kitchen facilities are shared, the housing must be a commercial establishment that provides either room, board, or both for fair market value compensation.

(g) In the OSIP and OSIPM programs only:

(A) The biological and adoptive children of either spouse.

(B) Recipients of EXT, GA, MAA, MAF, OHP, OSIP, OSIPM, or QMB.

Stat. Auth.: ORS 411.060, 411.070, 412.049, 414.042
Stats. Implemented: ORS 411.060, 411.070, 412.049, 414.042
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 6-1994, f. & cert. ef. 4-1-94; AFS 13-1995, f. 6-29-95, cert. ef. 7-1-95; AFS 17-1998, f. & cert. ef. 10-1-98; SSP 33-2003, f. 12-31-03, cert. ef. 1-4-04; SSP 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-155-0270
Room and Board Standard; OSIPM

For an OSIPM program client in a community based care (see OAR 461-001-0000) facility, the room and board standard is $552.70. A client residing in a community based care facility must pay room and board.

Stat. Auth.: ORS 411.060, 411.070, 411.704 & 411.706
Stats. Implemented: ORS 411.060, 411.070, 411.704 & 411.706
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 30-1990, f. 12-31-90, cert. ef. 1-1-91; AFS 8-1992, f. & cert. ef. 4-1-92; AFS 35-1992, f. 12-31-92, cert. ef. 1-1-93; AFS 29-1993, f. 12-30-93, cert. ef. 1-1-94; AFS 29-1994, f. 12-29-94, cert. ef. 1-1-95; AFS 41-1995, f. 12-26-95, cert. ef. 1-1-96; AFS 42-1996, f. 12-31-96, cert. ef. 1-1-97; AFS 24-1997, f. 12-31-97, cert. ef. 1-1-98; AFS 25-1998, f. 12-28-98, cert. ef. 1-1-99; AFS 16-1999, f. 12-29-99, cert. ef. 1-1-00; AFS 13-2000, f. & cert. ef. 5-1-00; AFS 34-2000, f. 12-22-00, cert. ef. 1-1-01; AFS 27-2001, f. 12-21-01, cert. ef. 1-1-02; AFS 22-2002, f. 12-31-02, cert. ef. 1-1-03; SSP 33-2003, f. 12-31-03, cert. ef. 1-4-04; SSP 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 19-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 14-2007, f. 12-31-07, cert. ef. 1-1-08; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 26-2008, f. 12-31-08, cert. ef. 1-1-09; SSP 39-2009(Temp), f. 12-31-09, cert. ef. 1-1-10 thru 6-30-10; SSP 18-2010, f. & cert. ef. 7-1-10; SSP 35-2011, f. 12-27-11, cert. ef. 1-1-12; SSP 39-2012(Temp), f. 12-28-12, cert. ef. 1-1-13 thru 6-30-13; SSP 1-2013(Temp), f. & cert. ef. 1-8-13 thru 6-30-13; SSP 8-2013, f. & cert. ef. 4-1-13; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-155-0530
Special Need; Food for Guide Dogs and Special Assistance Animals

(1) For an OSIP or OSIPM program client receiving SSI, having an adjusted income less than the OSIPM program standard under OAR 461-155-0250, or receiving home and community-based care (see OAR 461-001-0030), a food allowance is allowed for guide dogs and special assistance animals that are individually trained to:

(a) Meet the client's specific medical needs by performing tasks, such as alerting and protecting a client who is having a seizure; or

(b) Perform specific physical tasks that the client is unable to do, such as picking up items that are dropped, turning on light switches, and pulling a wheelchair.

(2) The maximum amount the Department authorizes for this special need is $50 per month.

(3) Authorization of this special need must be based on a proven medical need to sustain the client's independence.

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060, 411.706

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 12-1993, f. & cert. ef. 7-1-93; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-155-0575
Special Need; In-home Supplement; OSIPM

In the OSIPM program:

(1) The Department may provide a monthly supplementary payment for a client who meets the requirements of all of the following subsections:

(a) The client must receive SSI as his or her only source of income.

(b) The client must receive home and community-based care (see OAR 461-001-0030) in-home services or State Plan Personal Care Services authorized under OAR chapter 411, division 034.

(2) An eligible client (under section (1) of this rule) receives a $30 monthly payment. The payment is considered reimbursement for uncovered assistance needs.

Stat. Auth.: ORS 411.060, 411.070, 411.404 & 411.706
Stats. Implemented: ORS 411.060, 411.070, 411.083, 411.404, 411.704 & 411.706
Hist.: SSP 11-2011(Temp), f. 3-31-11, cert. ef. 4-1-11 thru 9-28-11; SSP 17-2011, f. & cert. ef. 7-1-11; SSP 21-2011(Temp), f. & cert. ef. 7-15-11 thru 1-11-12; SSP 31-2011(Temp), f. & cert. ef. 12-1-11 thru 1-11-12; Administrative correction, 2-6-12; SSP 33-2012(Temp), f. 10-31-12, cert. ef. 11-1-12 thru 4-30-13; SSP 8-2013, f. & cert. ef. 4-1-13; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-155-0580
Special Need; Laundry Allowances

(1) OSIP and OSIPM clients who are receiving SSI or home and community-based care (see OAR 461-001-0030) or have adjusted income less than the OSIPM program income standard under OAR 461-155-0250, and GA and GAM clients, are eligible for a laundry allowance if they have proven, excessive, coin-operated laundry facility costs and do not:

(a) Have their own laundry facilities; or

(b) Reside in an adult foster care home, assisted living facility, nursing facility, residential care facility, or specialized living facility, unless the specialized living facility is apartment based.

(2) This allowance may not exceed the amount required to wash and dry the laundry.

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060, 411.706
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 2-1992, f. 1-30-92, cert. ef. 2-1-92; AFS 12-1993, f. & cert. ef. 7-1-93; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-155-0630
Special Need; Community Based Care; OSIPM

In the OSIPM program:

(1) A client is considered living in a community based care facility (see OAR 461-001-0000) if the client resides at one of the following care settings licensed by the Department:

(a) Adult Foster Care.

(b) Residential Care.

(c) Assisted Living.

(d) Specialized Living.

(e) Group Care Home.

(2) In determining eligibility for OSIPM for an individual receiving care in a 24-hour mental health residential care setting, such as an adult foster home, residential treatment home, residential treatment facility, or a secure treatment facility, the special need (see OAR 461-155-0010) is the amount of the service payment authorized by the Department and is added to the OSIP maintenance standard.

(3) If a client who meets the applicable income requirements begins living in a community based care facility:

(a) Payment for room and board may be authorized during the month of admission at the initial placement, limited to the approved rate.

(b) Room and board payments may be paid to the community based care facility during the temporary absence of a client if all of the following criteria are met:

(A) The absence occurs because the client is admitted to a hospital or nursing home.

(B) The Department determines the intent of the client to return to the community based care facility.

(C) The community based care facility is willing to accept the room and board payment.

(D) The client returns one month following the month in which the absence began.

(4) Spouses who each receive SSI and receive services in a community based care facility, are eligible for a payment in the amount that equals the difference between the OSIPM standard for a one-person need group and the individual's total countable income. If one spouse has income above the OSIPM standard, the excess income is applied to the other spouse's countable income.

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 12-1991(Temp), f. & cert. ef. 7-1-91; AFS 16-1991, f. 8-27-91, cert. ef. 9-1-91; AFS 2-1992, f. 1-30-92, cert. ef. 2-1-92; AFS 13-1994, f. & cert. ef. 7-1-94; SSP 22-2004, f. & cert. ef. 10-1-04; SSP 19-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 10-2007, f. & cert. ef. 10-1-07; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-155-0640
Special Need; Restaurant Meals

(1) To receive the restaurant meals special need payment, OSIP and OSIPM clients who are receiving SSI, home and community-based care (see OAR 461-001-0030), or have adjusted income less than the OSIPM program income standard under OAR 461-155-0250, and GA and GAM clients, must have proven medical and nutritional needs that cannot be met with meals purchased with SNAP program benefits.

(2) A client living in his or her own home who is unable to prepare his or her own meals, but is eligible for SNAP program benefits, may have his or her meals prepared by attendants that volunteer or are compensated by the Seniors and People with Disabilities Division In-Home Services program. A client also may receive, if eligible, Meals on Wheels services to supplement his or her diet.

(3) The payment standard for restaurant meals is $60 per month.

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060, 411.706
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 12-1991(Temp), f. & cert. ef. 7-1-91; AFS 16-1991, f. 8-27-91, cert. ef. 9-1-91; AFS 19-1991(Temp), f. & cert. ef. 10-1-91; AFS 2-1992, f. 1-30-92, cert. ef. 2-1-92; AFS 12-1993, f. & cert. ef. 7-1-93; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-155-0660
Special Need; Accommodation Allowance

(1) An OSIP or OSIPM program client living in a nursing facility is not eligible for an accommodation allowance. An OSIP or OSIPM program client living in a nonstandard living arrangement (see OAR 461-001-0000) is not eligible for an accommodation allowance unless he or she is receiving, or is eligible to receive after a temporary absence, home and community-based care (see OAR 461-001-0030) in-home services. An OSIP or OSIPM program client receiving SSI or having an adjusted income less than the OSIPM program income standard (except a client in a nursing facility) or eligible to receive or receiving home and community-based care in-home services is allowed an accommodation allowance if the client is 18 years of age or older and meets the criteria in section (2) or (3) of this rule.

(2) Temporary absence of client from home.

(a) A temporary accommodation allowance may be authorized, when permitted under section (1) of this rule, if a client meets the following criteria:

(A) The client leaves his or her home or rental property and enters an adult foster care facility, assisted living facility, group care home, hospital, nursing facility, residential care facility, specialized living facility, or state psychiatric institution;

(B) The client cannot afford to keep the home without the allowance;

(C) The client will be able to return home within six months of leaving, according to a written statement from a primary practitioner, RN, or PAS (pre-admission screening) RN; and

(D) The home will accommodate the service plan of the client when the client returns.

(b) The allowance may be authorized for six months. If, after six months, the client continues to meet the criteria in subsection (a) of this section, an extension may be approved in writing by a supervisor.

(c) The accommodation allowance equals the total of the client's housing cost, including taxes and insurance, plus the limited standard utility allowance for the SNAP program provided in OAR 461-160-0420.

(3) Additional cost for accommodation. A client meeting the criteria in section (1) of this rule may receive an accommodation allowance if the client's shelter cost exceeds the shelter standard in OAR 461-155-0250(2) and the requirements of one of the following subsections are met:

(a) The client has a documented increase in rent associated with access by an individual with a disability; or

(b) The client has been assessed to need a live-in provider, has accepted the services of a live-in provider, and requires an additional bedroom for the live-in provider.

(4) The accommodation allowance is determined as follows:

(a) For a client who receives an accommodation allowance based on increased costs associated with access by an individual with a disability, only the additional increase in cost for the accommodation is allowed.

(b) For a client who receives an accommodation allowance based on the need for an additional bedroom for a live-in provider, the amount of the accommodation allowance is the limited standard utility allowance for the SNAP program under OAR 461-160-0420 plus:

(A) One-third of the monthly rental cost; or

(B) One-third of the monthly payment on the property agreement (including mortgage, trust deed, or land sale contract). The property agreement is the agreement existing at the time the client is approved for the accommodation allowance. The accommodation allowance for the housing portion ends if the debt is refinanced, unless the refinancing was done only to reduce the original property agreement's interest rate or total monthly payment amount and the owner realized no direct or indirect payment of the home's equity value from the refinancing.

(i) If the refinancing requirement under this paragraph is met, the amount of the accommodation allowance is one-third of the refinanced property agreement amount plus the limited standard utility allowance under OAR 461-160-0420.

(ii) If the refinancing requirement under this paragraph is not met and the housing portion of the accommodation allowance ends, the client remains eligible only for the limited standard utility allowance portion under OAR 461-160-0420.

(5) Special requirements.

(a) A client who rents and qualifies for an allowance under section (3) of this rule must take the steps necessary to obtain subsidized housing under any federal or state housing program. A client who fails, at any time, to take the steps necessary to obtain subsidized housing reasonably available is ineligible for the allowance. A client, who has been denied or revoked from participation in any rent subsidy program based on the client's own actions is ineligible for benefits under this rule.

(b) A client who rents housing and refuses subsidized housing will no longer be eligible for an accommodation allowance, except that if the housing that is offered is not suitable, related to accommodations, and the client continues to have increased costs related to accommodations in the client's current living situation, the accommodation allowance may continue until such time as appropriate subsidized housing is found.

Stat. Auth.: ORS 411.060, 411.070, 411.704, 411.706

Stats. Implemented: ORS 411.060, 411.070, 411.704, 411.706

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 12-1991(Temp), f. & cert. ef. 7-1-91; AFS 16-1991, f. 8-27-91, cert. ef. 9-1-91; AFS 2-1992, f. 1-30-92, cert. ef. 2-1-92; AFS 12-1993, f. & cert. ef. 7-1-93; AFS 23-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 1-1999(Temp), f. & cert. ef. 2-1-99 thru 7-31-99; AFS 3-1999, f. 3-31-99, cert. ef. 4-1-99; AFS 9-1999, f. & cert. ef. 7-1-99; AFS 25-2000, f. 9-29-00, cert. ef. 10-1-00; SSP 22-2004, f. & cert. ef. 10-1-04; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 13-2009, f. & cert. ef. 7-1-09; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 25-2011, f. 9-30-11, cert. ef. 10-1-11; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-160-0055

Medical Costs That are Deductible; GA, GAM, OSIP, OSIPM, SNAP

(1) This rule applies only to SNAP filing group (see OAR 461-110-0370) members who are elderly (see OAR 461-001-0015) or who have a disability (see OAR 461-001-0015), and to clients in the GA, GAM, OSIP, and OSIPM programs.

(2) Medical costs are deductible to the extent a deduction is authorized in OAR 461-160-0415 and 461-160-0430 and in this rule.

(3) Health and hospitalization insurance premiums and coinsurance are deductible. In the OSIPM and SNAP programs, health insurance premiums paid less frequently than monthly may be prorated over the period covered by the premium.

(4) In the OSIPM and SNAP programs:

(a) Long-term care insurance premiums are deductible if the insurance pays for services while an individual is:

(A) Receiving home and community-based care (see OAR 461-001-0030);

(B) Receiving nursing facility services; or

(C) In an intermediate care facility for the mentally retarded (ICF/MR).

(b) A policy that is set up to pay a lump sum, similar to life insurance, is not deductible.

(5) The cost of a medical service is deductible if it is:

(a) Provided by, prescribed by, or used under the direction of a licensed medical practitioner; or

(b) Except in the SNAP program, a medical necessity approved by the Department.

(6) Medical deductions are also allowed for, among other things, the cost of:

(a) Medical and dental care, including psychotherapy, rehabilitation services, hospitalization, and outpatient treatment.

(b) Prescription drugs and over-the-counter medications prescribed by a licensed practitioner, the annual fee for a drug prescription card, medical supplies and equipment, dentures, hearing aids, prostheses, and prescribed eyeglasses.

(c) In the SNAP program, such items as the following:

(A) Nursing care, nursing home care, and hospitalization, including payments for an individual who was a member of the filing group immediately prior to entering a hospital or a nursing home certified by the state. Deduction of these payments is also allowed for an individual who was a member of the filing group immediately prior to death if the remaining filing group members are legally responsible for payment of the expenses.

(B) Services of an attendant, home health aid, housekeeper, or provider of dependent care necessary due to the client's age or illness, including an amount equal to a one-person SNAP benefit group (see OAR 461-110-0750) if the client furnishes the majority of an attendant's meals.

(C) Prescribed assistance animals (such as a Seeing Eye Dog, Hearing Dog, or Housekeeper Monkey) that have received special training to provide a service to the client. This deduction includes the cost of acquiring these animals, their training, food, and veterinarian bills.

(D) Reasonable costs for transportation and lodging needed to obtain medical treatment or services.

(E) Installment plan arrangements made before a bill becomes past due. The expense is not deducted if the client defaults and makes a second agreement.

(7) In the SNAP program, the costs for and related to medical use of marijuana, including registry identification cards, are not deductible.

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404 & 411.816

Stats. Implemented: ORS 409.010, 411.060, 411.070, 411.404 & 411.816

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 30-1990, f. 12-31-90, cert. ef. 1-1-91; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 28-1992, f. & cert. ef. 10-1-92; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 3-1997, f. 3-31-97, cert. ef. 4-1-97; AFS 10-2002, f. & cert. ef. 7-1-02; SSP 20-2004(Temp), f. & cert. ef. 9-7-04 thru 12-31-04; SSP 22-2004, f. & cert. ef. 10-1-04; SSP 23-2004(Temp), f. & cert. ef. 10-1-04 thru 12-31-04; SSP 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 7-2005, f. & cert. ef. 7-1-05; SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; SSP 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 14-2007, f. 12-31-07, cert. ef. 1-1-08; SSP 27-2012(Temp), f. & cert. ef. 7-12-12 thru 1-8-13; SSP 37-2012, f. 12-28-12, cert. ef. 1-1-13; SSP 8-2013, f. & cert. ef. 4-1-13; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-160-0540

Determining Financial Eligibility and Benefits; QMB and OSIPM (except OSIPM-EPD) Living in the Community

(1) This rule is used to determine financial eligibility for QMB program clients and OSIPM (except OSIPM-EPD) program clients who:

(a) Live in the community;

(b) Do not receive SSI; and

(c) Do not receive home and community-based care (see OAR 461-001-0030).

(2) In the OSIPM program, to determine eligibility for clients residing in a 24-hour mental health residential care setting, such as an adult foster home, residential treatment home, residential treatment facility, or a secure treatment facility, the amount of the service payment is added to the adjusted income standard defined in 461 155 0250(3). The sum of the service payment and the OSIPM program adjusted income standard must be greater than the client's adjusted income. If the sum of the service payment and the OSIPM program standard is less than the adjusted income, the client is not eligible. For all other OSIPM program clients, they are eligible if their adjusted income is less than the OSIPM program standard.

(3) In the QMB-BAS program, a client is eligible if his or her adjusted income is equal to or less than the QMB program adjusted income standard.

(4) In the QMB-SMB program, a client is eligible if his or her adjusted income is less than the adjusted income standard.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.706

Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.706

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 20-1990, f. 8-17-90, cert. ef. 9-1-90; AFS 1-1999(Temp), f. & cert. ef. 2-1-99 thru 7-31-99; AFS 7-1999, f. 4-27-99, cert. ef. 5-1-99; AFS 10-2002, f. & cert. ef. 7-1-02; SSP 22-2004, f. & cert. ef. 10-1-04; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-160-0550

Income Deductions; Non-SSI OSIP (except OSIP-EPD) and OSIPM (except OSIPM-EPD) in the Community When There Are No Children in the Household Group

(1) For purposes of this rule, "child" means a natural or adopted child of an individual or a natural or adopted child of either member of a married couple.

(2) This rule is used to determine adjusted income (see OAR 461-001-0000) for all clients in the OSIP (except OSIP-EPD) and OSIPM (except OSIPM-EPD) programs who:

(a) Live in the community;

(b) Are not assumed eligible (see OAR 461-135-0010);

(c) Do not receive home and community-based care (see OAR 461-001-0030); and

(d) Do not have at least one child in the household group (see OAR 461-110-0210).

(3) To determine adjusted income for clients described in section (2) of this rule, deductions from the countable (see OAR 461-001-0000) income of the financial group (see OAR 461-110-0530) are made in the following order:

(a) One standard deduction of $20 from unearned income. This deduction may be taken from earned income if the client has less than $20 in unearned income.

(b) One standard earned income deduction of:

(A) $65 for OSIP-AD, OSIP-OAA, OSIPM-AD, and OSIPM-OAA clients who are not blind; or

(B) $85 for OSIP-AB and OSIPM-AB clients who are blind.

(c) An income deduction for documented impairment-related work expenses or blind work expenses.

(d) One half of the remaining earned income.

(e) Deductions under a plan for self-support.

Stat. Auth.: ORS 411.060, 411.070 & 414.042

Stats. Implemented: ORS 411.060, 411.070 & 414.042

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 20-1990, f. 8-17-90, cert. ef. 9-1-90; AFS 28-1992, f. & cert. ef. 10-1-92; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 1-1999(Temp), f. & cert. ef. 2-1-99 thru 7-31-99; AFS 7-1999, f. 4-27-99, cert. ef. 5-1-99; AFS 25-2000, f. 9-29-00, cert. ef. 10-1-00; AFS 6-2001, f. 3-30-01, cert. ef. 4-1-01; AFS 13-2002, f. & cert. ef. 10-1-02; SSP 29-2003(Temp), f. 10-31-03, cert. ef. 11-1-03 thru 3-31-04; SSP 6-2004, f. & cert. ef. 4-1-04; SSP 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 14-2007, f. 12-31-07, cert. ef. 1-1-08; SSP 17-2008, f. & cert. ef. 7-1-08; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 25-2008(Temp), f. 12-31-08, cert. ef. 1-1-09 thru 6-30-09; SSP 5-2009, f. & cert. ef. 4-1-09; SSP 13-2009, f. & cert. ef. 7-1-09; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-160-0551

Income Deductions; Non-SSI OSIP (except OSIP-EPD) and OSIPM (except OSIPM-EPD) in the Community When There Are Children in the Household Group

(1) For purposes of this rule:

(a) Ineligible person means an individual who is not eligible to receive either SSI or TANF benefits.

(b) Child means a natural or adopted child of an individual or a natural or adopted child of either member of a married couple.

(2) This rule is used to determine adjusted income (see OAR 461-001-0000) for clients in the OSIP (except OSIP-EPD) and OSIPM (except OSIPM-EPD) programs who:

(a) Live in the community;

(b) Are not assumed eligible (see OAR 461-135-0010);

(c) Do not receive home and community-based care (see OAR 461-001-0030); and

(d) Have children in the household group (see OAR 461-110-0210).

(3) To determine adjusted income for clients described in section (2) of this rule, deductions from the countable (see OAR 461-001-0000) income of the financial group (see OAR 461-110-0530) are made in the following order:

(a) An allocation as described below:

(A) When an adult is applying, income is allocated (see paragraph (C) of this subsection) from an ineligible spouse included in the financial group to each ineligible child of the couple.

(B) When a child is applying:

(i) Income from ineligible parents is first allocated to each ineligible child in the household.

(ii) Second, the remaining income from subparagraph (i) of this paragraph is reduced as provided in subsections (b) through (f) of this section.

(iii) Third, the remaining income is reduced by the non-SSI OSIP and OSIPM adjusted income standard of the:

(I) Couple if both parents live with the child; or

(II) Individual if only one ineligible parent lives with the child.

(iv) Fourth, the remainder is deemed equally to each child applicant in the household.

(v) The income deemed to the child is added to the other income of the child and deductions are taken as described in subsections (b) through (f) of this section to calculate the child's adjusted income.

(C) The maximum amount of each allocation under paragraphs (A) and (B) of this subsection is the difference between the couple and the individual SSI Standard. The allocation for paragraphs (A) and (B) of this subsection is reduced by the other countable income of each ineligible child. An allocation is taken from unearned income first, and any remaining allocation is then taken from earned income.

(b) One standard deduction of $20 from unearned income. This deduction may be taken from earned income if the client has less than $20 in unearned income.

(c) One standard earned income deduction of:

(A) $65 for clients in the OSIP-AD, OSIP-OAA, OSIPM-AD, and OSIPM-OAA programs; or

(B) $85 for clients in the OSIP-AB and OSIPM-AB programs.

(d) An income deduction for documented impairment-related work expenses or blind work expenses.

(e) One half of the remaining earned income.

(f) Deductions under a plan for self-support for clients in the OSIP-AB, OSIP-AD, OSIPM-AB, and OSIPM-AD programs.

Stat. Auth.: ORS 411.060, 411.070, 414.042

Stats. Implemented: ORS 411.060, 411.070, 414.042

Hist.: SSP 17-2008, f. & cert. ef. 7-1-08; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 25-2008(Temp), f. 12-31-08, cert. ef. 1-1-09 thru 6-30-09; SSP 5-2009, f. & cert. ef. 4-1-09; SSP 13-2009, f. & cert. ef. 7-1-09; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-160-0610

Client Liability; OSIPM (except OSIPM-EPD)

(1) A client in the OSIPM (except OSIPM-EPD) program who receives long-term care (see OAR 461-001-0000) services must, in order to remain eligible, make the payment required by this rule, except as provided in sections (2) to (6) of this rule. The client must apply his or her adjusted income to the cost of the care or service. This amount is the client liability. If the client's adjusted income exceeds the cost of care or service, the client must pay the full cost of care but has no additional liability.

(2) A client who receives SSI, or is deemed to receive SSI under section 1619(b) of the Social Security Act (42 U.S.C. § 1382h(b)), is eligible for OSIPM program benefits without having to make a payment.

(3) The IC service payment of a client in the OSIPM-IC program is reduced by the amount of his or her liability.

(4) The following clients, if they receive the services described in section (5) of this rule, are exempt from payments required by this rule:

(a) A disabled adult child under OAR 461-135-0830.

(b) A widow or widower under OAR 461-135-0820.

(c) A Pickle amendment client under OAR 461-135-0780.

(5) A client identified in section (4) of this rule is exempt from payments required by this rule if the client receives:

(a) Home and community-based care (see OAR 461-001-0030); or

(b) Mental health services and lives in a mental health residential treatment facility. For purposes of this rule, only the following types of treatment centers qualify as a mental health residential treatment facility:

(A) A mental health adult foster home.

(B) A mental health residential treatment home.

(C) A mental health residential treatment facility.

(D) A mental health secure residential treatment facility.

(6) In the initial month of placement, a client may be exempt from payments required under this rule if the Department determines that the client's income has been exhausted prior to placement. If any income remains, the client must contribute to the cost of care or service.

(7) A client residing in an acute care hospital is exempt from payments required by this rule while residing in the acute care hospital. If a service benefit was received prior to admission to the acute care hospital, payment must be made for that service.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.706

Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.706

Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 29-1994, f. 12-29-94, cert. ef. 1-1-95; AFS 1-1999(Temp), f. & cert. ef. 2-1-99 thru 7-31-99; AFS 7-1999, f. 4-27-99, cert. ef. 5-1-99; AFS 10-2002, f. & cert. ef. 7-1-02; SSP 16-2003, f. & cert. ef. 7-1-03; SSP 22-2004, f. & cert. ef. 10-1-04; SSP 8-2005(Temp), f. & cert. ef. 7-1-05 thru 10-1-05; SSP 9-2005(Temp), f. & cert. ef. 7-6-05 thru 10-1-05; SSP 14-2005, f. 9-30-05, cert. ef. 10-1-05; SSP 19-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 23-2008, f. & cert. ef. 10-1-08; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-165-0100

Issuance Date of Benefit

(1) For all programs except the EA and SNAP programs:

(a) An authorized cash payment check is dated on the first day of the payment period or as soon as practicable thereafter.

(b) Checks and medical cards are mailed so they can be delivered to the client on the first day of each month except in the following cases:

(A) Initial month benefits for cases that are new, reopened, or restored.

(B) Cases with no special needs or service coding.

(C) If the first day of the month falls on Sunday or a holiday, the check is mailed in time for the client to receive it on Saturday or the mail day preceding the holiday.

(D) Checks redirected to the branch office may be released during the last workday preceding a weekend or holiday.

(c) Benefits issued by EBT will be available on the first day of each month, except for the following:

(A) Initial month benefits for cases that are new, reopened, or restored.

(B) Benefits held by the branch office.

(2) EA clients must receive their checks, either direct or vendor, in time to meet their emergent needs.

(3) SNAP benefits are available as follows:

(a) SNAP benefits issued by EBT are available in the EBT account on the day of the month corresponding to the last digit of the client's case number except for the following:

(A) The benefits for the initial month of eligibility for a new or reopened case.

(B) The benefits for the seventh month of the certification period for a case in the semi-annual reporting system.

(b) SNAP benefits issued through the SNAP cash-out are available as follows:

(A) Benefits accessed through an EBT account are available on the first day of the month.

(B) Checks are mailed on the first day of the month.

(C) Direct-deposit funds are available on the third working day of the month.

(4) For SNAP changes that could not be made in time to adjust the monthly allotment, a supplement is issued within 10 days of the date the change was reported.

(5) In the OSIPM program, a medical ID card is mailed on the first of each month to clients receiving home and community-based care (see OAR 461-001-0030) who contribute to their services by paying their excess income into a maintenance trust and agency account. The client's medical card is not held until the payment is received. If payment is not received before the end of the payment month, the Department considers the QMB program for the following month.

Stat. Auth.: ORS 411.060, 411.070, 411.404, 411.704, 411.706, 411.816, 412.014, 412.049
Stats. Implemented: ORS 411.060, 411.070, 411.404, 411.704, 411.706, 411.816, 412.014, 412.049
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 25-1991, f. 12-30-91, cert. ef. 1-1-92; AFS 16-1993, f. & cert. ef. 9-1-93; AFS 6-1994, f. & cert. ef. 4-1-94; AFS 10-1995, f. 3-30-95, cert. ef. 4-1-95; AFS 3-1997, f. 3-31-97, cert. ef. 4-1-97; AFS 13-1997, f. 8-28-97, cert. ef. 9-1-97; SSP 22-2004, f. & cert. ef. 10-1-04; SSP 24-2004, f. 12-30-04, cert. ef. 1-1-05; SSP 5-2010, f. & cert. ef. 4-1-10; SSP 18-2010, f. & cert. ef. 7-1-10; SSP 32-2010, f. & cert. ef. 10-1-10; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-175-0230
Notice Situation; Nonstandard Living Situations

(1) In the SNAP program:

(a) A timely continuing benefit decision notice (see OAR 461-001-0000) is sent to terminate, suspend, or reduce benefits if the notice occurs as a result of any of the following situations:

(A) A client has been admitted or committed to an institution.

(B) A client has been placed in foster care, skilled nursing care, intermediate care, or long term hospitalization.

(C) A client is placed in official custody or a correctional facility.

(D) A client enters a drug or alcohol residential treatment facility.

(E) A client leaves a drug or alcohol residential treatment facility without reapplying for SNAP benefits.

(b) No decision notice (see OAR 461-001-0000) is required if the Department determines that a resident of a group living (see OAR 461-001-0015) facility or a drug or alcohol treatment center is ineligible as a result of one of the following actions taken against the center or facility:

(A) Disqualification by Food and Nutrition Services (FNS) as an authorized representative.

(B) Loss of certification with the Department.

(c) A resident of a facility that is disqualified or loses its certification as described in subsection (b) of this section may still qualify for SNAP benefits through a separate application.

(2) Except as provided in section (3) of this rule, for all programs except the SNAP program, a basic decision notice (see OAR 461-001-0000) is sent to terminate, suspend, or reduce benefits in each of the following situations:

(a) The client has been admitted or committed to an institution.

(b) The client has been placed in skilled nursing care, intermediate care, or long-term hospitalization.

(c) The client is placed in official custody or a correctional facility.

(3) In the OSIPM program, a client receiving home and community-based care (see OAR 461-001-0030) or long term care services is sent:

(a) A timely continuing benefit decision notice in each of the following situations:

(A) A reduction or closure of services occurs as the result of a process of reevaluating both the functional impairment levels of a client and the requirements of a client for assistance in performing activities of daily living.

(B) Services are closing because the client has not paid the client liability.

(C) The client receives benefits in the OSIP-IC or OSIPM-IC program, and benefits will end under OAR 411-030-0100.

(D) There is a change in special needs as described in OAR 461-180-0040.

(b) A continuing benefit decision notice (see OAR 461-001-0000) when there is an increase in the client liability.

(c) A basic decision notice when there is a decrease in the client liability.

Stat. Auth.: ORS 411.060, 411.101, 411.816, 412.049
Stats. Implemented: ORS 411.060, 411.095, 411.099, 411.101, 411.111, 411.816, 412.049
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 6-1994, f. & cert. ef. 4-1-94; AFS 13-1995, f. 6-29-95, cert. ef. 7-1-95; AFS 11-2001, f. 6-29-01, cert. ef. 7-1-01; SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; SSP 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-180-0044
Effective Dates; Income Cap Trust

The effective date for an income cap trust that makes a client income-eligible for long term care or home and community-based care (see OAR 461-001-0030) under 461-135-0750 and 461-145-0540(9)(c) is the first day of the month in which the trust document is signed.

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060
Hist.: SSP 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 16-2006(Temp), f. 12-29-06, cert. ef. 1-1-07 thru 3-31-07; SSP 4-2007, f. 3-30-07, cert. ef. 4-1-07; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-185-0050
Client Pay-In System

(1) Except as provided in sections (2) and (3) of this rule, a client who receives home and community-based care (see OAR 461-001-0030) in-home services and has countable income above the payment standard for the benefit group must pay to the Department the lesser of the following amounts as a condition of being eligible for home and community-based care in-home services:

(a) The difference between their adjusted income and the payment standard for the number in the benefit group.

(b) The actual cost of home and community-based care in-home services.

(2) The service liability of clients in the OSIP-IC and OSIPM-IC programs is calculated in accordance with section (1) of this rule. Clients in the OSIP-IC and OSIPM-IC programs do not pay the Department directly. The IC service payment of these clients will be reduced by the amount of their liability.

(3) A client exempt from payments under OAR 461-160-0610(2) is exempt from the payment required by this rule.

(4) Each month, the Department will send the client an invoice requesting payment based on the calculation in section (1) of this rule.

(5) Payments must be received by the Department in the month of service.

Stat. Auth.: ORS 411.060, 411.070, 411.404
Stats. Implemented: ORS 411.060, 411.070, 411.404
Hist.: AFS 29-1994, f. 12-29-94, cert. ef. 1-1-95; AFS 11-2001, f. 6-29-01, cert. ef. 7-1-01; SSP 8-2005(Temp), f. & cert. ef. 7-1-05 thru 10-1-05; SSP 14-2005, f. 9-30-05, cert. ef. 10-1-05; SSP 19-2005, f. 12-30-05, cert. ef. 1-1-06; SSP 14-2006, f. 9-29-06, cert. ef. 10-1-06; SSP 15-2006, f. 12-29-06, cert. ef. 1-1-07; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

461-195-0521
Calculation of Overpayments

This rule specifies how the Department calculates an overpayment (see OAR 461-195-0501).

(1) The Department calculates an overpayment by determining the amount the client received or the payment made by the Department on behalf of the client that exceeds the amount for which the client was eligible.

(2) When a filing group, ineligible student, or authorized representative (see OAR 461-115-0090) fails to report income, the Department calculates and determines the overpayment by assigning unreported income to the applicable budget month without averaging the unreported income, except:

(a) A client's earned income reported quarterly from the Employment Department is considered received by the client in equal amounts during the months identified in the report.

(b) In the ERDC, MAA, MAF, REF, SNAP, and TANF programs, a client's actual self-employment income is annualized retrospectively to calculate the overpayment.

(3) When using prospective budgeting (see OAR division 461-150) and the actual income differs from the amount determined under OAR 461-150-0020(2), there may be a client error overpayment (see OAR 461-195-0501) only when the filing group, ineligible student, or authorized representative withheld information, failed to report a change, or provided inaccurate information. In such a case, the Department uses the actual income to determine the amount of an overpayment.

(4) When a filing group, ineligible student, or authorized representative fails to report all earned income within the reporting time frame, the earned income deduction (see OAR 461-160-0160, 461-160-0190, 461-160-0430, 461-160-0550, and 461-160-0552) is applied as follows:

(a) In the OSIP, OSIPM, QMB, and REFM programs, the Department allows the earned income deduction.

(b) In the MAA, MAF, REF, and TANF programs, the Department allows the earned income deduction when good cause (see section (5) of this rule) exists.

(c) In the SNAP program, no deduction is applied to earned income not timely reported.

(5) For the purposes of OAR 461-195-0501 to 461-195-0561, "good cause" means circumstances beyond the client's reasonable control that caused the client to be unable to report income timely and accurately.

(6) When support is retained:

(a) In the TANF program, the amount of support (other than cash medical support) the Department of Justice retains as a current reimbursement each month is added to other income to determine eligibility. When a client is not eligible for TANF program benefits, the overpayment is offset by the support the Department of Justice retains as a current reimbursement.

(b) In the medical programs, the amount of the cash medical support the Department retains each month is excluded income and not used to determine eligibility for medical program benefits. When a client has incurred a medical program overpayment, the overpayment is offset by the amount of the cash medical support the Department retains during each month of the overpayment.

(7) In the REF and TANF programs, when a client directly receives support used to determine eligibility or calculate benefits, the overpayment is:

(a) If still eligible for REF or TANF program benefits, the amount of support the client received directly; or

(b) If no longer eligible for REF or TANF program benefits, the amount of program benefits the client received.

(8) When an overpayment occurs due to the failure of an individual to reimburse the Department, when required by law to do so, for benefits or services (including cash medical support) provided for a need for which that individual is compensated by another source, the overpayment is limited to the lesser of the following:

(a) The amount of the payment from the Department;

(b) Cash medical support; or

(c) The amount by which the total of all payments exceeds the amount payable for such a need under the Department's rules.

(9) Benefits paid during a required notice period (see OAR 461-175-0050) are included in the calculation of the overpayment when:

(a) The filing group, ineligible student, or authorized representative failed to report a change within the reporting time frame under OAR 461-170-0011; and

(b) Sufficient time existed for the Department to adjust the benefits to prevent the overpayment if the filing group, ineligible student, or authorized representative had reported the change at any time within the reporting time frame.

(10) In the SNAP program:

(a) If the benefit group (see OAR 461-110-0750) was categorically eligible, there is no overpayment based on resources.

(b) For a filing group (see OAR 461-110-0370) found eligible for SNAP program benefits under OAR 461-135-0505(1)(a) to (c), and the actual income made the group ineligible for the related program, the group remains categorically eligible for SNAP program benefits as long as the eligibility requirement under OAR 461-135-0505(1)(d) is met. A benefit group of one or two individuals would be entitled to at least the minimum SNAP program benefit allotment under OAR 461-165-0060.

(c) For a filing group found eligible for SNAP program benefits only under OAR 461-135-0505(1)(d), and the actual income equals or exceeds 185 percent of the Federal Poverty Level, the filing group is no longer categorically eligible. The overpayment is the amount of SNAP program benefits incorrectly received.

(11) In the OSIP and OSIPM programs, when a client does not pay his or her share of the cost of services (see OAR 461-160-0610) or the OSIP-EPD or OSIPM-EPD program participant fee (see OAR 461-160-0800) in the month in which it is due, an overpayment is calculated as follows:

(a) All payments made by the Department on behalf of the client during the month in question are totaled, including but not limited to any payment for:

(A) Capitation;

(B) Long term care services;

(C) Medical expenses for the month in question;

(D) Medicare buy-in (when not concurrently eligible for an MSP);

(E) Medicare Part D;

(F) Mileage reimbursement;

(G) Special needs under OAR 461-155-0500 to 416-155-0710; and

(H) Home and community-based care (see OAR 461-001-0030), including home delivered meals and non-medical transportation.

(b) Any partial or late liability payment made by a client receiving home and community-based care in-home services or participant fee paid by an OSIP-EPD or OSIPM-EPD program client is subtracted from the total calculated under subsection (a) of this section. The remainder, if any, is the amount of the overpayment.

(12) When a client's liability is unreduced pending the outcome of a contested case hearing about that liability the overpayment is the difference between the liability amount determined in the final order and the amount, if any, the client has repaid.

(13) In the BCCM, CEC, CEM, EXT, MAA, MAF, OHP-CHP, OHP-OPC, OHP-OPP, OHP-OPU, OHP-OP6, OSIPM, QMB, REFM, and SAC programs if the client was not eligible for one program, but during the period in question was eligible for another program:

(a) With the same benefit level, there is no overpayment.

(b) With a lesser benefit level, the overpayment is the amount of medical program benefit payments made on behalf of the client exceeding the amount for which the client was eligible.

(14) When an overpayment is caused by administrative error (see OAR 461-195-0501), any overpayment of GA, OSIP, REF, SFPSS, or TANF program benefits is not counted as income when determining eligibility for the EXT, GAM, MAA, MAF, OSIPM, REFM, and SAC programs.

(15) Credit against an overpayment is allowed as follows:

(a) In the GA, REF, and TANF programs, a credit is allowed for a client's payment for medical services made during the period covered by the overpayment, in an amount not to exceed the Department fee schedule for the service, but credit is not allowed for an elective procedure unless the Department authorized the procedure prior to its completion.

(b) In the SNAP program, if the overpayment was caused by unreported earned income, verified child care costs are allowed as a credit to the extent the costs would have been deductible under OAR 461-160-0040 and 461-160-0430.

(c) In the SFPSS and TANF programs, if the overpayment is caused by reported earned income, a credit is allowed for the Post-TANF grant if the client meets eligibility under OAR 461-135-1250 and the client has received less than 12 months of Post-TANF program benefits.

(d) In all programs, for an underpayment of benefits.

(16) In the SNAP program, in compliance with the American Recovery and Reinvestment Act of 2009, effective April 1, 2009 through September 30, 2009, the amount between the normal Thrifty Food Plan (TFP) benefit amount under this section and the increased TFP benefit amount under OAR 461-155-0190 is not counted in the overpayment amount unless the filing group was ineligible for SNAP program benefits. [Table not included. See ED. NOTE]

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409.050, 411.060, 411.070, 411.404, 411.660, 411.706, 411.816, 412.014, 412.049, 412.124, 414.231

Stats. Implemented: ORS 409.010, 411.060, 411.070, 411.404, 411.620, 411.630, 411.635, 411.640, 411.660, 411.690, 411.706, 411.816, 412.014, 412.049, 412.124, 414.231, 416.350

Hist.: AFS 3-2000, f. 1-31-00, cert. ef. 2-1-00; AFS 25-2000, f. 9-29-00, cert. ef. 10-1-00; AFS 6-2001, f. 3-30-01, cert. ef. 4-1-01; AFS 27-2001, f. 12-21-01, cert. ef. 1-1-02; AFS 22-

2002, f. 12-31-02, cert ef. 1-1-03; SSP 23-2003, f. & cert. ef. 10-1-03; SSP 4-2005, f. & cert. ef. 4-1-05; SSP 10-2006, f. 6-30-06, cert. ef. 7-1-06; SSP 20-2003, f. & cert. ef. 8-15-03; SSP 7-2007, f. 6-29-07, cert. ef. 7-1-07; SSP 14-2007, f. 12-31-07, cert. ef. 1-1-08; SSP 8-2008, f. & cert. ef. 4-1-08; SSP 6-2009(Temp), f. & cert. ef. 4-1-09 thru 9-28-09; SSP 13-2009, f. & cert. ef. 7-1-09; SSP 28-2009, f. & cert. ef. 10-1-09; SSP 38-2009, f. 12-31-09, cert. ef. 1-1-10; SSP 17-2011, f. & cert. ef. 7-1-11; SSP 25-2011, f. 9-30-11, cert. ef. 10-1-11; SSP 13-2013, f. & cert. ef. 7-1-13; SSP 17-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

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Department of Justice
Chapter 137

Rule Caption: Child support modifications, administrative hearing requests and corrected hearings orders
Adm. Order No.: DOJ 5-2013
Filed with Sec. of State: 7-8-2013
Certified to be Effective: 7-8-13
Notice Publication Date: 6-1-2013
Rules Amended: 137-055-2140, 137-055-2160, 137-055-3420, 137-055-3430
Subject: OAR 137-055-2140 is amended to authorize administrative law judges of the Office of Administrative Hearings to make corrections to their orders and to issue amended orders.

OAR 137-055-2160 is amended to clarify what is required in a party's request for an administrative hearing.

OAR 137-055-3420 is amended to clarify that the Program will issue a modification of a child support order or judgment, if a written request is received from a party, or the family is currently receiving TANF, and the order is over 35 months old.

OAR 137-055-3430 is amended to include the definition for "substantial compliance" for purposes of determining whether an order qualifies for a modification. It also clarifies criteria for substantial change in circumstance and removes definitions for "temporary modification" and "employment related change of income."
Rules Coordinator: Carol Riches—(503) 947-4700

137-055-2140
Delegations to Administrative Law Judge

Administrative law judges of the Office of Administrative Hearings are authorized to do the following:

(1) Issue final orders without first issuing proposed orders.

(2) Issue final orders by default in cases described in OAR 137-003-0670 or 137-003-0672, except in a case authorized by ORS 416.415 or as authorized in section (3). An administrative law judge is authorized to issue a final order by default in a case authorized by ORS 416.425(5) but not in any other case authorized by ORS 416.425, unless section (4) of this rule applies.

(3) Issue final orders by default when the nonrequesting party(ies) fails to appear for a hearing conducted under ORS 25.020(13), or issue a dismissal with prejudice when the requesting party fails to appear for a hearing conducted under ORS 25.020(13).

(4) Issue an order dismissing a temporary modification, as defined in OAR 137-055-3430, if the party seeking a temporary modification fails to appear for a scheduled hearing, without further action by the administrator.

(5) Correct mistakes in hearing orders issued by OAH pursuant to ORS 180.345, including scrivener errors and substantive errors, at any time within 30 days of the issuance of the order.

(a) Orders in which scrivener errors have been corrected must be marked "Corrected Order".

(b) Orders in which substantive errors have been amended must be marked "Amended Order".

(c) Corrected and amended orders must contain notice to the parties of appeal rights as provided in ORS 416.427 and must be mailed to the parties by regular mail at the parties' contact addresses.

(d) Notwithstanding section (c) of this rule, the Administrator may receive such orders electronically.

(6) Determine whether a reschedule request should be granted pursuant to OAR 137-003-0670(2), based on whether the requester=s failure to appear for a scheduled hearing was beyond the reasonable control of the party.

(7) Issue final orders granting or denying late hearing requests pursuant to OAR 137-003-0528.

(8) Provide to each party the information required to be given under ORS 183.413(2) or OAR 137-003-0510(1).

(9) Order and control discovery.

Stat. Auth.: ORS 25.020 & 180.345
Stats. Implemented: ORS, 25.020, 180.345, 416.415 & 416.425
Hist.: AFS 21-2000, f. & cert. ef. 8-1-00; AFS 32-2000, f. 11-29-00, cert. ef. 12-1-00, Renumbered from 461-195-0801; AFS 28-2001, f. 12-28-01, cert. ef. 1-1-02; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-2140; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-2140; DOJ 7-2004, f. 3-30-04, cert. ef. 4-1-04; DOJ 16-2004, f. 12-30-04, cert. ef. 1-3-05; DOJ 5-2005, f. & cert. ef. 7-15-05; DOJ 1-2006, f & cert. ef. 1-3-06; DOJ 4-2009(Temp), f. 5-6-09, cert. ef. 5-7-09 thru 11-1-09; DOJ 13-2009, f. & cert. ef. 10-30-09; DOJ 5-2013, f. & cert. ef. 7-8-13

137-055-2160
Requests for Hearing

(1) A request for hearing must be in writing and signed by the party, the party's authorized representative, or the administrator. The signature may be handwritten, typed or electronic.

(2) A request for hearing may be made on a form provided by the Child Support Program (CSP).

(3) A request for hearing must be received by the CSP office which issued the action within the time provided by law or notice in order to be considered timely.

(4) A new or amended request for hearing is not required from the requesting party to obtain a hearing if the administrator amends the order being appealed, unless the administrator notifies the requesting party that an additional request is required.

(5) When a party requests a hearing after the time specified by the administrator, the administrator will handle the request pursuant to OAR 137-003-0528, except that the administrator may accept the late request only if:

(a) The request is received before or within 60 days after entry of a final order by default;

(b) The circuit court has not approved the final order or there is no appeal of the final order pending with the circuit court, and

(c) The cause for failure to timely request the hearing was beyond the reasonable control of the party, unless other applicable statutes or Oregon Child Support Program administrative rules provide a different time frame or standard.

(6) Notwithstanding the provisions of section (5) of this rule, a request for hearing is not considered a late hearing request when:

(a) Parentage testing has been conducted pursuant to ORS 109.252 and 416.430 which includes the man as the biological father of the child, and a request for hearing has been received from a party 30 days from the date of service of the Notice of Intent to Enter Order/Judgment establishing paternity and the notice of parentage testing results; or

(b) A party has denied paternity and failed to appear for parentage tests, an order establishing paternity has been entered, and a request for hearing has been received from a party within 30 days from the date the order establishing paternity was mailed to the parties.

(7) For the purpose of computing any period of time under this rule, except as otherwise provided, any response period begins to run on the following date:

(a) If service is by certified mail, on the date the party signs a receipt for the mailing;

(b) If service is by regular mail:

(A) Three days after the mailing date if mailed to an address in Oregon;

(B) Seven days after the mailing date if mailed to an address outside Oregon; or

(c) The date evidence shows the party received the mailing.

(8) Except as provided in subsection (9)(b) the dates in section (7) are computed based on calendar days, not business days.

(9)(a) In computing any period of time under this rule, do not count the date of mailing as the first day; and

(b) If the last day falls on a Saturday, Sunday or legal holiday, do not count that day as a calendar day.

(10) The provisions of sections (7) through (9) do not apply to service on a party by regular mail to complete substitute service. For substitute service, the service date is the date the document is mailed.

Stat. Auth.: ORS 180.345
Stats. Implemented: ORS 183.415
Hist.: AFS 5-1995, f. & ef. 2-6-95; AFS 26-1997, f. 12-31-97, cert. ef. 1-1-98; AFS 21-2000, f. & cert. ef. 8-1-00; AFS 32-2000, f. 11-29-00, cert. ef. 12-1-00, Renumbered from 461-195-0830; AFS 28-2001, f. 12-28-01, cert. ef. 1-1-02; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-2160; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-2160; DOJ 2-2006(Temp), f. & cert. ef. 1-3-06 thru 6-30-06; DOJ 5-2006, f. 6-29-06, cert. ef. 7-3-06; DOJ 6-2006, f. & cert. ef. 10-2-06; DOJ 10-2008, f. & cert. ef. 7-1-08; DOJ 2-2010(Temp), f. & cert. ef. 1-4-10 thru 7-1-10; DOJ 11-2010, f. & cert. ef. 7-1-10; DOJ 13-2011, f. 12-30-11, cert. ef. 1-3-12; DOJ 5-2013, f. & cert. ef. 7-8-13

137-055-3420
Periodic Review and Modification of Child Support Order Amounts

(1) "Periodic Review" means a proceeding initiated under ORS 25.287(1) to modify an existing order to comply with the child support guidelines.

(2)The administrator will initiate a periodic review if a written request is received from any party or the family is currently receiving TANF, and 35 months have passed since the date:

(a) The most recent support order took effect, or

(b) The most recent order determining that the support order should not be adjusted was signed. For purposes of calculating the 35-month time period, a suspension and temporary modification order entered pursuant to ORS 416.425(13) will not be considered.

(3) The administrator must complete the modification of the existing order within 180 days of receiving a written request for a periodic review, initiating the mandatory review, or locating the non-requesting party(ies), whichever occurs later.

(4) The administrator is responsible for conducting a periodic review in this state or for requesting that another jurisdiction conduct a review pursuant to OAR 137-055-7190. As provided in ORS 110.429 and 110.432, the law of the jurisdiction reviewing the order applies in determining if a basis for modification exists.

(5) On receipt of a written request for a periodic review or when a mandatory periodic review is required, the administrator will notify the parties of the review in writing, allowing the parties 30 days to provide information that may affect the support calculation.

(6) If there is an adult child on the case, the proposed modification will be a tiered order as defined in OAR 137-055-1020.

(7) For all child support cases receiving support enforcement services under ORS 25.080, the Child Support Program (CSP) will annually notify the parties:

(a) Of their right to request a periodic review of the amount of support ordered; and

(b) That the CSP will perform a mandatory periodic review and adjustment if the family is currently receiving TANF.

Stat. Auth.: ORS 180.345 & 416.455
Stats. Implemented: ORS 25.080, 25.287, 25.321–25.343, 107.135 & 416.425
Hist.: AFS 65-1989, f. 10-31-89, cert. ef. 11-1-89; AFS 11-1992(Temp), f. & cert. ef. 4-30-92; AFS 26-1992, f. & cert. ef. 9-30-92; AFS 20-1993, f. 10-11-93, cert. ef. 10-13-93; AFS 21-1994, f. 9-13-94, cert. ef. 12-1-94; AFS 17-1997(Temp), f. & cert. ef. 9-16-97; AFS 17-1997(Temp) Repealed by AFS 23-1997, f. 12-29-97, cert. ef. 1-1-98; AFS 23-1997, f. 12-29-97, cert. ef. 1-1-98; AFS 75-1998, f. 9-11-98, cert. ef. 9-15-98; AFS 13-1999, f. 10-29-99, cert. ef. 11-1-99; AFS 9-2000, f. 3-13-00, cert. ef. 4-1-00; AFS 21-2000, f. & cert. ef. 8-1-00; AFS 32-2000, f. 11-29-00, cert. ef. 12-1-00, Renumbered from 461-195-0072; AFS 23-2001, f. 10-2-01, cert. ef. 10-6-01; AFS 28-2001, f. 12-28-01, cert. ef. 1-1-02; SSP 4-2003, f. 2-25-03, cert. ef. 3-1-03; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-3420; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-3420; DOJ 2-2004, f. 1-2-04 cert. ef. 1-5-04; DOJ 10-2004, f. & cert. ef. 7-1-04; DOJ 4-2005, f. & cert. ef. 4-1-05; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06; DOJ 1-2006, f & cert. ef. 1-3-06; DOJ 5-2006, f. 6-29-06, cert. ef. 7-3-06; DOJ 8-2007, f. 9-28-07, cert. ef. 10-1-07; DOJ 11-2008(Temp), f. & cert. ef. 7-15-08 thru 9-30-08; DOJ 12-2008(Temp), f. & cert. ef. 10-1-08 thru 3-29-09; DOJ 14-2008(Temp), f. & cert. ef. 10-7-08 thru 3-29-09; DOJ 1-2009, f. & cert. ef. 1-2-09; DOJ 4-2009(Temp), f. 5-6-09, cert. ef. 5-7-09 thru 11-1-09; DOJ 13-2009, f. & cert. ef. 10-30-09; DOJ 1-2010, f. & cert. ef. 1-4-10; DOJ 3-2011(Temp), f. & cert. ef. 3-31-11 thru 9-26-11; DOJ 4-2011, f. & cert. ef. 7-1-11; DOJ 5-2013, f. & cert. ef. 7-8-13

137-055-3430
Substantial Change in Circumstance Modification of Child Support Order Amounts

(1) For purposes of this rule: "Substantial compliance" means that the difference between the existing support order and the amount calculated using current guidelines is not greater than $50 or 15% of the current guideline amount, whichever is less.

(2) Notwithstanding OAR 137-055-3420, proceedings may be initiated at any time to review and modify a support obligation based upon a substantial change in circumstance.

(3) The administrator will conduct a review based on a request for a change of circumstance modification when:

(a) Oregon has jurisdiction to modify; and

(b) The administrator:

(A) Receives a request for modification based on a change of circumstance and at least 60 days have passed from the date the existing support order was entered. For those cases where a review is requested pursuant to paragraphs (3)(c)(H) or (I), there is no need for 60 days to have passed; or

(B) Determines that a modification should be initiated based on the administrator's motion; and

(c) At least one of the following criteria are met:

(A) A change in the written parenting time agreement or order has taken place;

(B) The financial or household circumstances of one or more of the parties are different now than they were at the time the order was entered;

(C) Social Security benefits received on behalf of a child due to a parent's disability or retirement were not previously considered in the order or they were considered in an action initiated before May 12, 2003;

(D) Veterans benefits received on behalf of a child due to a parent's disability or retirement were not previously considered in the order or they were considered in an action initiated before May 12, 2003;

(E) Survivors' and Dependents' Education Assistance benefits received by the child or on behalf of the child were not previously considered in the order;

(F) Since the date of the last order, the obligor has been incarcerated, as defined in OAR 137-055-3300;

(G) The needs of the child(ren) have changed;

(H) There is a need to add or change medical support provisions for a child;

(I) A change in the physical custody of a minor child has taken place;

(J) An order is being modified to include a subsequent child of the parties or to remove a child of the parties; or

(K) A child who is 18 years of age or older and under 21 years of age does not qualify as a child attending school under ORS 107.108 and OAR 137-055-5110 and, pursuant to ORS 107.108(10), tiered order provisions will be added, removed or changed. Tiered order has the meaning given in OAR 137-055-1020,

(d) And the requesting party (if other than the administrator):

(A) Makes a written or verbal request for modification based on a substantial change of circumstance;

(B) Pursuant to ORS 416.425, provides appropriate documentation for the criteria in subsection (c) of this section showing that a substantial change of circumstance has occurred; and

(C) Completes a Uniform Income Statement or Uniform Support Affidavit.

(4) Upon receipt of a request for modification, or on the administrator's initiative, the administrator will notify the parties of the review in writing, allowing the parties 30 days to provide information that may affect the support calculation.

(5) A request for modification will be granted:

(a) If the order is not in substantial compliance with the guidelines and the request was due to one of the criteria in paragraphs (3)(c)(A) through (3)(c)(G).

(b) Whether or not the order is in substantial compliance with the guidelines, so long as:

(A) The request was due to one of the criteria in paragraphs (3)(c)(H) through (3)(c)(K), or

(B) The new calculation:

(i) Includes consent by the parties as provided in OAR 137-050-0765;

(ii) Includes compelling factors as provided in OAR 137-050-0750;

(iii) Includes application of rebuttals, as provided in OAR 137-050-0760; or

(iv) Is for a modification to consider receipt of Social Security or Veterans benefits as provided in paragraphs (3)(c)(C) or (D).

(6) If the request for modification is granted, the administrator will advise the parties of the guideline child support obligation. Notification may be by motion for modification and will include a request for hearing form. If there is an adult child on the case, the proposed modification will be a tiered order as defined in OAR 137-055-1020.

(7) If a request under this rule is denied, the administrator will notify the requesting party in writing within 30 days of the denial and inform the party of their right to file a motion for modification as provided in ORS 416.425. The administrator will provide the party with information on how to obtain the Oregon Judicial Department packet that has been developed for this purpose.

(8) No provision of this rule prevents the parties from obtaining the services of private legal counsel at any time to pursue modification of the support order.

(9) If a request for review and modification is received because a change in the physical custody of the minor child(ren) has taken place, a party may also request a credit back to the date the change in physical custody took place in accordance with OAR 137-055-5510.

Stat. Auth.: ORS 180.345 & 416.455
Stats. Implemented: ORS 25.080, 25.287, 25.321–25.343, 107.108, 107.135 & 416.425
Hist.: DOJ 10-2004, f. & cert. ef. 7-1-04; DOJ 16-2004, f. 12-30-04, cert. ef. 1-3-05; DOJ 4-2005, f. & cert. ef. 4-1-05; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06; DOJ 1-2006, f & cert. ef. 1-3-06; DOJ 5-2006, f. 6-29-06, cert. ef. 7-3-06; DOJ 8-2007, f. 9-28-07, cert. ef. 10-1-07; DOJ 4-2009(Temp), f. 5-6-09, cert. ef. 5-7-09 thru 11-1-09; DOJ 6-

2009(Temp), f. & cert. ef. 5-14-09 thru 11-1-09; DOJ 13-2009, f. & cert. ef. 10-30-09; DOJ 13-2010(Temp), f. & cert. ef. 7-1-10 thru 12-27-10; DOJ 19-2010, f. 12-20-10, cert. ef. 12-27-10; DOJ 13-2011, f. 12-30-11, cert. ef. 1-3-12; DOJ 6-2012(Temp), f. & cert. ef. 5-24-12 thru 11-20-12; DOJ 15-2012, f. 9-27-12, cert. ef. 10-1-12; DOJ 5-2013, f. & cert. ef. 7-8-13

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Department of Oregon State Police,
Office of State Fire Marshal
Chapter 837

Rule Caption: Adopt by reference the Hazardous Substance Possession Fee Schedules effective July 1, 2013.
Adm. Order No.: OSFM 2-2013
Filed with Sec. of State: 6-26-2013
Certified to be Effective: 7-1-13
Notice Publication Date: 6-1-2013
Rules Amended: 837-090-1030
Subject: Fee schedules are established by Office of State Fire Marshal for any person possession a hazardous substance at a facility in this state. This rule amendment adopts, by reference, the Hazardous Substance Possession Fee schedule effective July 1, 2013.
Rules Coordinator: Connie Dalke—(503) 934-8211

837-090-1030
State Fee Schedules

(1) Three state fee schedules shall be developed annually as the basis for assessing each person returning a Hazardous Substance Information Survey (see OAR 837-090-1000 to 837-090-1045) a Hazardous Substance Possession Fee.

(2) The annual fee assessed under each schedule shall be based upon the single largest maximum aggregate quantity of substance reported in the Hazardous Substance Information Survey, that is manufactured, stored, or otherwise possessed by a facility during the survey year.

(3) The programs to be funded from fees collected under ORS 453.396 to 453.414 and these rules, and the range of the fee schedules that may be considered, beginning July 1989, are as follows:

(a) For funding the Community Right to Know and Protection Act, not less than $25 and not more than $2,000 per facility;

(b) For funding the Toxics Use Reduction and Hazardous Waste Reduction Act, not less than $25 and not more than $2,000 per facility;

(c) For each employer's share of a total of up to $1 million to be deposited into the Orphan Site Account established under ORS 465.381, not less than zero and not more than $9,000 per facility. This schedule shall not require an employer to pay a total more than $25,000 for all facilities.

(4) Employers that believe a billing error has occured may request a fee review. Fee review requests must be made in writing to the Office of State Fire Marshal within 20 days of the billing mail date. Fee review requests must include the company name, facility ID number, site address, name of the substance the fee was based on, amount of the fee assessed, telephone number and the reason for requesting a review.

(5) Any dispute as to the amount or validity of a hazardous substance fee assessment shall be resolved in accordance with the appeals process procedures outlined in the Administrative Procedures Act (APA), ORS 183.025 to 183.725, unless specifically addressed in these rules.

(6) The Office of State Fire Marshal adopts by reference the Hazardous Substance Possession Fee schedules effective July 1, 2013. Copies of these fee schedules are available for review at the central office of the State Fire Marshal during normal business hours or online at http://www.oregon.gov/OSP/SFM/Pages/index.aspx

(7) If a person can provide evidence that all or part of their propane is derived from the refining of crude oil, the fee assessment Reporting Quantity Range and the fee shall be adjusted accordingly;

(8) If a person can provide evidence that all or part of their propane is used to power motor vehicles licensed for public highway use, the fee assessment Reporting Quantity Range and the fee shall be adjusted accordingly.

Stat. Auth.: ORS 453.408, 833 & 1071
Stats. Implemented: ORS 453.402
Hist.: FM 4-1989, f. & cert. ef. 8-31-89; FM 7-1990(Temp), f. & cert. ef. 11-15-90; FM 3-1991(Temp), f. & cert. ef. 12-23-91; FM 7-1992, f. 6-15-92, cert. ef. 7-15-92, Renumbered from 837-090-0900; FM 9-1992(Temp), f. & cert. ef. 9-28-92; OSFM 9-2002, f. 11-14-02, cert. ef. 11-17-02; OSFM 2-2013, f. 6-26-13, cert. ef. 7-1-13

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Rule Caption: Increases the Petroleum Load Fee that supports the Regional Hazardous Materials Response Teams.
Adm. Order No.: OSFM 3-2013
Filed with Sec. of State: 6-26-2013
Certified to be Effective: 6-30-13
Notice Publication Date: 6-1-2013
Rules Amended: 837-090-1145
Subject: Rule is being modified to increase the Petroleum Load Fee as follows: effective July 1, 2013 the fee shall be $6 per load, effective July 1, 2014 the fee shall be $7 per load, and effective July 1, 2015 the fee shall be $8 per load.
Rules Coordinator: Connie Dalke—(503) 934-8211

837-090-1145
Petroleum Load Fee

(1) As provided in ORS 465.101 to 465.131, the petroleum load withdrawal fee is established to carry out the state's oil, hazardous materials and hazardous substance emergency response program as it relates to the maintenance, operation, and use of the public highways, roads, streets, and roadside rest areas. Effective July 1, 2013 the fee shall be $6.00 per load, effective July 1, 2014 the fee shall be $7.00 per load and effective July 1, 2015 the fee shall be $8.00 per load.

(2) Fee collection by the Department of Revenue will begin October 1, 1993.

Stat. Auth.: ORS 465.106
Stats. Implemented: ORS 465.106
Hist.: FM 5-1993, f. & cert. ef. 11-1-93; OSFM 9-2002, f. 11-14-02, cert. ef. 11-17-02; OSFM 12-2005, f. & cert. ef. 8-15-05; OSFM 3-2009, f. & cert. ef. 11-18-09; OSFM 11-2012(Temp), f. 11-1-12, cert. ef. 1-1-13 thru 6-30-13; OSFM 3-2013, f. 6-26-13, cert. ef. 6-30-13

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Rule Caption: Regional Hazardous Material Response Teams cost recovery schedules established in 2013–2015 Team Contracts.
Adm. Order No.: OSFM 4-2013
Filed with Sec. of State: 6-26-2013
Certified to be Effective: 7-1-13
Notice Publication Date: 6-1-2013
Rules Amended: 837-120-0080
Subject: Rule is being modified to adopt by reference the schedule of emergency response costs of the Regional Hazardous Materials Response teams, as established in the 2013–2015 team Contracts.
Rules Coordinator: Connie Dalke—(503) 934-8211

837-120-0080
Response Fee Schedules

(1) The fee schedules agreed to by the state and contractors as part of the regional and limited hazardous materials emergency response team agreements and contracts, shall serve as the basis for assessment of response costs.

(2) The Office of State Fire Marshal adopts by reference the schedule of emergency response costs in Exhibit F & G as established in the 2013-15 Regional Hazardous Materials Response Teams Contracts.

(3) Current regional and limited hazardous materials emergency response team agreements and contracts are available for review upon appointment at the central Offices of the State Fire Marshal between the hours of 8 a.m. and 5 p.m. weekdays.

Stat. Auth.: ORS 453.367
Stats. Implemented: ORS 453.374
Hist.: FM 8-1992, f. 7-15-92, cert. ef. 8-15-92; OSFM 4-2013, f. 6-26-13, cert. ef. 7-1-13

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Rule Caption: Reportable quantities of hazardous substances in Community Right-To-Know Survey and Compliance Programs
Adm. Order No.: OSFM 5-2013
Filed with Sec. of State: 6-26-2013
Certified to be Effective: 6-26-13
Notice Publication Date: 6-1-2013
Rules Amended: 837-085-0030, 837-085-0040, 837-085-0080, 837-085-0300
Subject: 837-085-0030 deletes voluntary reporting for persons with facilities not covered.

837-085-0040(38) modifies the definition of "liquefied gas."

837-085-0040(39) and 837-085-0300 are amended for housekeeping purposes.

837-085-0080 modifies the reportable quantity for liquefied gases.
Rules Coordinator: Connie Dalke—(503) 934-8211

837-085-0030
Covered Employers, Owners, Operators and the North American Industry Classification System (NAICS)

(1) Persons operating one or more facilities, where hazardous substances are present in reportable quantities are required to notify the Office of State Fire Marshal within 30 days and are subject to the hazardous substance information reporting requirements contained in ORS 453.307 to 453.414 and OAR 837-085-0090.

(2) Persons operating facilities within North American Industry Classification System (NAICS) codes that have been identified by the Office of State Fire Marshal as having the potential to possess, store or otherwise use hazardous substances in reportable quantities are subject to the hazardous substance information reporting requirements contained in ORS 453.307 to 453.414 and OAR 837-085-0090 if sent a Hazardous Substance Information Survey by the Office of State Fire Marshal.

(3) Persons classified within construction or logging NAICS codes are not required to report their temporary work sites unless required in 40 CFR 370.

(4) Persons having facilities classified within the NAICS code 424930 (Flower, Nursery Stock, and Florists' Supplies Merchant Wholesalers) or the NAICS code 444220 (Nursery, Garden Center, and Farm Supply Stores), that do not sell, or otherwise market, products that require a Material Safety Data Sheet to be developed by the manufacturer, are not required to report for that facility unless required in 40 CFR 370.

Stat. Auth.: ORS 453.367
Stats. Implemented: ORS 453.307(2)
Hist.: FM 1-1994, f. & cert. ef. 1-14-94; FM 4-1994, f. 12-14-94, cert. ef. 12-15-94; OSFM 9-2002, f. 11-14-02, cert. ef. 11-17-02; OSFM 5-2005, f. 3-31-05, cert. ef. 4-1-05; OSFM 1-2010, f. 1-27-10, cert. ef. 2-1-10; OSFM 5-2013, f. & cert. ef. 6-26-13

837-085-0040
Definitions

(1) "Act" means the Community Right-to-Know and Protection Act, ORS 453.307 to 453.414.

(2) "Appeal" means the written request for a contested case in order to contest the required submission of Hazardous Substance Information Survey information or to contest a "Notice of Noncompliance and Proposed/Final Penalty Assessment" order, or a response to a request for exemption.

(3) "Approved Form" means a form provided by or authorized by the Office of State Fire Marshal.

(4) "Audit" means the evaluation of covered employers, owners or operators to determine their level of compliance with the Oregon Community Right-to-Know and Protection Act.

(5) "Average Daily Amount" means the average amount of a hazardous substance present at a facility during the twelve-month survey period.

(6) "Chemical" means any element, chemical compound, or mixture of elements or compounds.

(7) "Chemical Name" means the scientific designation of a chemical in accordance with the nomenclature system developed by the International Union of Pure and Applied Chemistry (IUPAC) or the Chemical Abstracts Service's (CAS) rules of nomenclature.

(8) "Common Name" means any designation or identification such as code name, code number, trade name, brand name or generic name, used to identify a chemical other than by its chemical name.

(9) "Compliance Auditor" means a designated employee of the Office of State Fire Marshal whose responsibility is to conduct audits, identify noncompliance issues, propose penalties, establish correction dates and assist employers, owners, and operators in voluntarily complying with ORS 453.307 to 453.414.

(10) "Compliance or Due Date" means the date set for submitting a Hazardous Substance Information Survey, substantive change or other information requested by the Office of State Fire Marshal.

(11) "Compressed Gas" means:

(a) A gas or mixture of gases, in a container, having an absolute pressure exceeding 40 psi at 70° F (21.1° C); or

(b) A gas or mixture of gases, in a container, having an absolute pressure exceeding 104 psi at 130° F (54.4° C) regardless of the pressure at 70° F (21.1° C); or

(c) A liquid having a vapor pressure exceeding 40 psi at 100° F (37.8°C) as determined by ASTM D-323-72, Test Method of Vapor Pressure of Petroleum Products (Reid Method).

(12) "Confidential" means information submitted to a public body in confidence (ORS 192.502(3)).

(13) "Confidentiality Agreement" means a written agreement between a covered employer, owner or operator and an entity authorized under ORS 453.337 and OAR chapter 837, division 085 to request and receive trade secret information.

(14) "Correction Order" means a written order that directs an employer, owner or operator to submit Hazardous Substance Information Survey information.

(15) "Covered Employer, Owner or Operator" means:

(a) Any person operating a facility possessing reportable quantities of hazardous substances as defined by the Office of State Fire Marshal in OAR 837-085-0070.

(b) Any person operating a facility that the Office of State Fire Marshal believes has the potential to store, generate, use, or otherwise possess hazardous substances in reportable quantities.

(16) "Division" means OAR chapter 837, division 085 of the Office of State Fire Marshal.

(17) "Emergency" means any human caused or natural event or circumstance causing or threatening loss of life, injury to person or property, human suffering or financial loss which includes, but is not limited to, fire, explosion, flood, severe weather, drought, earthquake, volcanic activity, spills of oil or other substances, contamination, utility or transportation accidents, disease, blight, infestation, civil disturbance, riot, sabotage/war.

(18) "Emergency Services" means those activities provided by state or local government agencies with emergency operational responsibilities to prepare for or carry out any activity to prevent, minimize, respond to or recover from an emergency. Without limitation, these activities include coordination, preplanning, training, interagency liaison, fire fighting, hazardous substance management, law enforcement, medical, health or sanitation services, engineering or public works, search and rescue activities, public information, damage assessment, administration and fiscal management.

(19) "Emergency Service Agency" means an organization, which performs essential services for the public's benefit prior to, during, or following an emergency. This includes, but is not limited to, organizational units within local governments, such as emergency medical technicians, health, medical or sanitation services, public works or engineering, public information or communications.

(20) "Entity" means any individual trust, firm, association, corporation, partnership, joint stock company, joint venture, public or municipal corporation, commission, political subdivision, the state or any agency or commission thereof, interstate body, or the federal government or any agency thereof.

(21) "Exempted Substance" means a substance that is not required to be reported.

(22) "Exemption" means the written authority given to a person by the Office of State Fire Marshal, granting an exemption from the requirements of a rule or law.

(23) "Explosive" means a hazardous substance classified as an explosive by the U.S. Department of Transportation.

(24) "Extension" means the written authorization of the Office of State Fire Marshal to extend a compliance or due date.

(25) "Facility" means all buildings, equipment structures or other stationary items that are located on a single site or on contiguous or adjacent sites that are owned or operated by a covered employer, owner or operator.

(26) "Facility Representative" means any individual designated by an employer, owner or operator to serve as spokesperson or, in the absence of a designated spokesperson, the person in charge of a facility being audited.

(27) "Filed" means the receipt of a document by the Office of State Fire Marshal, except that an appeal will be considered filed upon receipt at any regional office of the Office of State Fire Marshal.

(28) "Fire District" means any agency having responsibility for providing fire protection services.

(29) "Fixed Facility" means a facility having permanent or non-mobile operations.

(30) "Hazard Classification" means the U.S. Department of Transportation hazard classes and divisions as defined in 49 CFR 173.2. However, when the definitions in 49 CFR 173.2 refer to transportation or hazards associated with transportation, they shall be deemed to refer to storage or other regulated activities under OAR chapter 837, division 085.

(31) "Hazardous Substance" means:

(a) Any substance designated as hazardous by the Director of the Department of Consumer and Business Services or by the Office of State Fire Marshal; or

(b) Any substance required to have a Material Safety Data Sheet (MSDS) pursuant to Oregon Occupational Safety and Health Division's OAR 437, division 2 (29 CFR 1910.1200), subdivision Z, and which appears on the list of Threshold Limit Values for Chemical Substances and

Physical Agents in the Work Environment by the American Conference of Governmental Industrial Hygienist (ACGIH); or

(c) Any substance required to have an MSDS pursuant to Oregon Occupational Safety and Health Division's OAR 437, division 2 (29 CFR 1910.1200), subdivision Z, except:

(A) Substances exempted by designation of the Office of State Fire Marshal; or

(B) Substances which are solids and do not react or dissolve and are stored in unprotected areas; or

(C) Substances exempted by the rules of OAR chapter 837, division 085; or

(D) Gases intended and used for human or animal ingestion or inhalation either directly or added to a product, if the gas is present at the site where ingestion or inhalation occurs; and the gas is not being used in a manufacturing process; and the gas is not a cryogenic; and the gas is not being stored at the site in a quantity that exceeds 1,000 cubic feet.

(d) Any substance for which a manufacturer is required to develop an MSDS, that presents a physical or health hazard to emergency response personnel or the public under normal conditions of use or during an emergency situation; or

(e) Any waste substance that presents a physical or health hazard to emergency response personnel or the public under normal conditions of use or during an emergency situation; or

(f) Any radioactive waste or radioactive material as defined in ORS 469.300(19) and radioactive substance as defined in 453.005.

(32) "Hazardous Substance Information Survey" means a hazardous substance report that covered employers, owners or operators are required to submit, on an approved form, to the Office of State Fire Marshal.

(33) "Health Professional" means a physician as defined in ORS 677.010, registered nurse, industrial hygienist, toxicologist, epidemiologist or emergency medical technician.

(34) "Highly Toxic Material" means a material which produces a lethal dose or lethal concentration which falls within any of the following categories:

(a) A chemical that has a median lethal dose (LD50) of 50 milligrams or less per kilogram of body weight when administered orally to albino rats weighing between 200 and 300 grams each;

(b) A chemical that has a median lethal dose (LD50) of 200 milligrams or less per kilogram of body weight when administered by continuous contact for 24 hours (or less if death occurs within 24 hours) with the bare skin of albino rabbits weighing between two and three kilograms each;

(c) A chemical that has a median lethal concentration (LC50) in air of 200 parts per million by volume or less of gas or vapor, or two milligrams per liter or less of mist, fume or dust, when administered by continuous inhalation for one hour (or less if death occurs within one hour) to albino rats weighing between 200 and 300 grams each;

(d) Mixture of these materials with ordinary materials, such as water, may not warrant a classification of highly toxic. While this system is basically simple in application, any hazard evaluation which is required for the precise categorization of this type of material shall be performed by experienced, technically competent persons.

(35) "Identity" means any chemical or common name that is indicated:

(a) On a Material Safety Data Sheet (MSDS) as required under OAR 437, division 2 (CFR 1910.1200), subdivision Z; or

(b) On shipping documents as required under 49 CFR 171-177 under the Transportation Safety Act of 1974 (49 U.S.C. 1801 et seq.); or

(c) On hazardous waste manifests as required by OAR chapter 340, division 102 as adopted by the Department of Environmental Quality; or

(d) On packaging or container labels as required under the Federal Insecticide, Fungicide, and Rodenticide Act (7 U.S.C. 136 et seq.) and labeling regulations issued under the Act by the Environmental Protection Agency; or

(e) On a radioactive material license as issued under OAR chapter 333, divisions 100 through 113 as adopted by the Radiation Control Section of the Health Division of the Oregon Department of Human Resources.

(36) "Incident" means the threatened or actual injury or damage to a human, wildlife, domestic animal or the environment, or any property loss resulting from a hazardous substance release.

(37) "Law Enforcement Agency" means county sheriffs, municipal police departments, state police, other police officers of this or other states or law enforcement agencies of the federal government.

(38) "Liquefied Gas" means a gas that is received and stored as a liquid through the use of pressure or temperature.

(39) "Material Safety Data Sheet (MSDS)" means written, printed or electronic material concerning a hazardous chemical which is prepared in accordance with OAR 437, division 2 (29 CFR 1910.1200), subdivision Z, Hazard Communication rules of the Occupational Safety and Health Division of the Department of Consumer and Business Services.

(40) "Maximum Amount" means the largest amount of a hazardous substance located at a facility at any one time during the 12-month survey period.

(41) "North American Industry Classification System" means a system developed by the Office of Management and Budget for the purpose of classifying establishments by the type of activity they engage in. The number assigned to each group classified is called the NAICS code.

(42) "No Longer Reportable" means a previously reported substance was not on site in a reportable quantity during the current survey period.

(43) "Noncompliance" means failure of a covered employer, owner or operator to comply with the Community Right-to-Know and Protection Act or its administrative rules.

(44) "Noncompliance Classification" means the category assigned to issues of noncompliance for the purposes of assessing a penalty.

(45) "Notice of Noncompliance and Proposed/Final Penalty Assessment Order" means a written document issued to covered employers, owners or operators that states they were not complying with the Community Right-to-Know and Protection Act, establishes correction dates and notifies them of penalty assessments.

(46) "Person" means any entity including, but not limited to, an individual, trust, firm, joint stock company, corporation, partnership, association, municipal corporation, political subdivision, interstate body, the state or any agency or commission thereof, or the federal government or any agency thereof.

(47) "Record" means any recorded information.

(48) "Repeat Noncompliance" means a covered employer, owner and or operator has failed to comply with the same rule of OAR 837-085 two or more times within a five year period of time.

(49) "Reportable Hazardous Substance" is a hazardous substance that is manufactured, generated, used, stored, possessed, or disposed of at a fixed site location by covered employers, owners, or operators at or above the reportable quantities at any time during the survey period.

(50) "Reportable Quantity" means the amount of hazardous substance that must be present at a facility before reporting is required.

(51) "Reporting Range" means a range of quantities assigned by the Office of State Fire Marshal for reporting hazardous substances.

(52) "Retail Gasoline Station" means a retail facility engaged in selling gasoline and/or diesel fuel principally to the public, for motor vehicle use on land.

(53) "Single Combined Survey" means a survey that has multiple substations reported on it.

(54) "Source Generation Sites" means facilities generating that which is relayed, pumped or stored by substations.

(55) "State Fire Marshal" means the State Fire Marshal or designee.

(56) "Substantive Change" means a change in hazardous substance reporting information that requires notification to the Office of State Fire Marshal.

(57) "Substation" means facilities that function only as electrical transmission relays, telephone transmission relays, pager transmission relays, cable TV transmission relays, cellular phone transmission relays, radar transmission relays, water storage reservoir, water pump or chlorinating stations, sewerage/storm water pump stations, natural gas pump stations or road sand storage.

(58) "Survey Period" means the 12 months preceding the date the Hazardous Substance Information Survey is mailed to, or completed by, the covered employer, owner or operator.

(59) "Temporary Worksite" means a single site location where activities, such as construction or logging, will occur for less than 24 months.

(60) "Trade Name" means the brand name or trademark given to a hazardous substance by a manufacturer or distributor.

(61) "Trade Secret" means, but is not limited to, any formula, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information which is not patented; which is known only to certain individuals within a commercial concern who are using it to fabricate, produce, or compound an article of trade or a service or to locate minerals or other substances having commercial value; and which gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.

(62) "Total Amount Transported from the facility" means the total amount of a hazardous substance that has been transported from the facility site during the 12-month survey period.

(63) "Total Amount Transported to the facility" means the total amount of a hazardous substance that has been transported on to the facility site during the 12-month survey period.

(64) "Waste Hazardous Substance" means any substance, which meets the Department of Environmental Quality's definition of "hazardous waste".

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 453.367

Stats. Implemented: ORS 453.357

Hist.: FM 1-1994, f. & cert. ef. 1-14-94; OSFM 1-1999, f. 2-2-99 & cert. ef. 2-3-99; OSFM 9-2002, f. 11-14-02, cert. ef. 11-17-02; OSFM 5-2005, f. 3-31-05, cert. ef. 4-1-05; OSFM 1-2010, f. 1-27-10, cert. ef. 2-1-10; OSFM 1-2013, f. 1-24-13, cert. ef. 2-1-13; OSFM 5-2013, f. & cert. ef. 6-26-13

837-085-0080

Hazardous Substance Information Survey — Required Survey Information

(1) Covered employers, owners, and operators must calculate the following for each hazardous substance manufactured, generated, used, stored, possessed or disposed of during the survey period:

(a) Average daily amount;

(b) Maximum amount onsite at one time;

(c) Maximum amount at each storage location reported;

(d) Total amount transported to the facility;

(e) Total amount transported from the facility.

(2) The amounts of hazardous substances shall be measured in the physical state assumed at "Standard Temperature and Pressure" (STP) or when released into the environment. Liquefied gases are under pressure in a liquid state in the container. The reportable quantity is determined as a liquid reportable in gallons.

(3) The amounts of hazardous substances must be reported in the following units:

(a) Solids must be reported in units of pounds;

(b) Liquids must be reported in units of gallons;

(c) Liquefied gases must be reported in units of gallons;

(d) Compressed gases that are not liquefied must be reported in units of cubic feet;

(e) Radioactive materials must be reported in units of millicuries.

(4) For a mixture, the total amount of the substance is reported regardless of the concentration of the hazardous substance in the mixture.

(5) The amounts of a hazardous substance with the same chemical composition in separate containers at one facility shall be added together for reporting purposes.

(6) Like substances which are exempted from the Hazardous Substance Possession Fee shall be grouped and reported together. Examples of these groups include, but are not limited to: Gasoline, motor oils, asphalt emulsion, and diesels.

(7) Water-based paints with the same major components shall be grouped and reported together. Solvent-based paints with the same major components shall be grouped and reported together.

Stat. Auth.: ORS 453.367

Stats. Implemented: ORS 453.317

Hist.: FM 1-1994, f. & cert. ef. 1-14-94; OSFM 1-1999, f. 2-2-99, cert. ef. 2-3-99; OSFM 9-2002, f. 11-14-02, cert. ef. 11-17-02; OSFM 5-2005, f. 3-31-05, cert. ef. 4-1-05; OSFM 1-2010, f. 1-27-10, cert. ef. 2-1-10; OSFM 1-2013, f. 1-24-13, cert. ef. 2-1-13; OSFM 5-2013, f. & cert. ef. 6-26-13

837-085-0300

Penalties for Class IV Noncompliance

(1) A penalty shall be calculated for each individual unreported radioactive substance, radioactive waste, explosive or highly toxic material. These substances are required to be reported at the "Lower Reporting Levels" (LRL) of five gallons, ten pounds or 20 cubic feet. Penalties for all Extremely Hazardous Substances shall be calculated at the LRL.

(2) A separate penalty shall be calculated for all other individual unreported hazardous substances. These substances are required to be reported at the "Upper Reporting Levels" (URL) of 500 gallons, pounds, or cubic feet. For the purpose of determining Class IV Noncompliance penalties, these substances shall be identified as URL substances.

(3) For the purpose of determining individual substances, Material Safety Data Sheets will be used.

(4) A penalty determination shall be made for Lower Reporting Levels (LRL) and Upper Reporting Levels (URL) substances using the following criteria:

(a) Substances required to be reported at the LRL will be subject to a penalty amount of $250 for each individual substance that is not reported;

(b) Substances required to be reported at the URL will be subject to a penalty amount of $100 for each individual substance that is not reported.

(5) Penalties for repeat class IV Noncompliance within a five year period of time shall be calculated in accordance with 837-085-0300 and increased using the following schedule:

2nd Instance — 3rd Instance — 4th Instance — 5th Instance

penalty x 2 — penalty x 4 — penalty x 8 — penalty x 16

Stat. Auth.: ORS 453.367

Stats. Implemented: ORS 435.357

Hist.: FM 1-1994, f. & cert. ef. 1-14-94; OSFM 9-2002, f. 11-14-02, cert. ef. 11-17-02; OSFM 5-2005, f. 3-31-05, cert. ef. 4-1-05; OSFM 1-2010, f. 1-27-10, cert. ef. 2-1-10; OSFM 5-2013, f. & cert. ef. 6-26-13

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Department of Oregon State Police, State Athletic Commission
Chapter 230

Rule Caption: Establish rule that requires boxing/mixed martial arts female competitors submit and pass pregnancy test.

Adm. Order No.: SAC 3-2013(Temp)

Filed with Sec. of State: 7-10-2013

Certified to be Effective: 7-10-13 thru 1-6-14

Notice Publication Date:

Rules Amended: 230-020-0330

Subject: Oregon Revised Statute (ORS) 463.113(1) authorizes the Oregon Athletic Commission (Commission) to adopt administrative rules for ". . .conducting professional boxing and mixed martial arts events that promote the safety and best interest of the contestants and of the public." Similarly, ORS 463.113(2) authorizes the Oregon Department of State Police (OSP) Superintendent to ". . .adopt and enforce rules for conducting professional boxing and mixed martial arts events that promote the safety and best interest of the contestants and of the public." The Oregon State Athletic Commission has initiated temporary rulemaking to amend OAR 230-020-0330 related to boxing and mixed martial arts competitions in Oregon. The rule amendment implements in Oregon a common industry practice designed to promote the health and safety of competitors, by adding into OAR 230-020-0330 a requirement that female boxing and mixed martial arts competitors submit and pass a pregnancy test in order to participate in the upcoming boxing or mixed martial arts event. The rule includes an option for waiver of the test requirement upon submission of documentation that the contestant has undergone a full hysterectomy. The rule also specifies the timing of the test and acceptable test methods.

Rules Coordinator: Shannon Peterson—(503) 934-0183

230-020-0330

Medical Disqualification

(1) The Superintendent must refuse to certify a boxer or mixed martial arts contestant if the examining physician or the Superintendent determines that withholding certification is necessary to preserve the health or safety of the boxer or mixed martial arts combatant.

(2) A boxer or mixed martial arts contestant is medically disqualified from competition if he or she:

(a) Has sustained a significant cut that is not completely healed;

(b) Has sustained three consecutive knockouts or TKOs, any knockout within the past 60 days, or any TKO within the past 30 days;

(c) Has sustained two knockouts within 90 days or a knockout in the first fight after a disqualification;

(d) Is not sufficiently conditioned to participate safely.

(3) A boxer or mixed martial arts contestant who has sustained three knockouts may be referred for neurological consultation.

(4) Pre-fight pregnancy test. Prior to participating in any boxing or mixed martial arts event, each female competitor must submit and pass a pregnancy test.

(a) For purposes of this rule, "pass" means the competitor tests negative for pregnancy.

(b) The pregnancy test must be administered during the pre-fight physical examination under the supervision of the examining physician or a female assistant authorized by the Commission, using a pregnancy test kit supplied by the Commission.

(i) Pregnancy test kits not supplied by the Commission shall not be accepted.

(ii) The female competitor shall be accompanied to the bathroom facility by the examining physician or authorized female assistant, shall be allowed to take the pregnancy test in privacy, and shall promptly provide the test to the examining physician for interpretation of the results. The female competitor may not carry personal belongings into the bathroom while taking the test.

(c) In place of the pregnancy test described in subsection (b) of this rule, a female competitor may submit a results report from a serum or urine pregnancy test administered within 14 days of the scheduled event by a clinical laboratory or licensed physician. The competitor must submit the results report to the Commission no less than 72 hours before the event.

(d) The Superintendent or the examining physician may waive the pre-fight pregnancy test upon submission of written documentation from a licensed physician or clinic showing that the female competitor has undergone a total hysterectomy.

(i) Waiver of the pre-fight pregnancy test requirement may not be provided for any other reason.

(ii) A competitor submitting such hysterectomy documentation to the Commission for the first time must do so no less than 72 hours prior to an event in which the competitor wishes to participate. Once adequate documentation of hysterectomy has been submitted by the competitor, the Commission may keep the documentation on file and the competitor shall not be required to re-submit the documentation for subsequent events unless re-submission is requested by the Commission.

(e) A competitor who tests positive for pregnancy may not participate in the boxing or mixed martial arts event for which the pregnancy test was submitted. A female competitor who fails to submit pregnancy test results or waiver documentation consistent with all requirements of this rule may not participate in the boxing or mixed martial arts event for which the pregnancy test was required. Nothing in this rule shall bar a competitor from seeking to establish eligibility to participate in subsequent events.

Stat. Auth.: ORS 463.113
Stats. Implemented: ORS 463.025 & 463.047
Hist.: BWC 1-1988, f. 3-22-88, cert. ef. 3-29-88; BWC 1-1991, f. & cert. ef. 9-20-91, Section (2) renumbered from 230-060-0150(2); BWC 1-1995, f. 10-10-95, cert. ef. 10-13-95; SAC 5-2008, f. 6-12-08, cert. ef. 7-1-08; SAC 1-2013, f. & cert. ef. 2-21-13; SAC 3-2013(Temp), f. & cert. ef. 7-10-13 thru 1-6-14

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Rule Caption: Establish rule that requires boxing/mixed martial arts female competitors submit and pass pregnancy test.
Adm. Order No.: SAC 4-2013(Temp)
Filed with Sec. of State: 7-10-2013
Certified to be Effective: 7-10-13 thru 1-6-14
Notice Publication Date:
Rules Amended: 230-020-0330
Subject: Oregon Revised Statute (ORS) 463.113(1) authorizes the Oregon Athletic Commission (Commission) to adopt administrative rules for ". . .conducting professional boxing and mixed martial arts events that promote the safety and best interest of the contestants and of the public." Similarly, ORS 463.113(2) authorizes the Oregon Department of State Police (OSP) Superintendent to ". . . adopt and enforce rules for conducting professional boxing and mixed martial arts events that promote the safety and best interest of the contestants and of the public." The Oregon State Athletic Commission has initiated temporary rulemaking to amend OAR 230-020-0330 related to boxing and mixed martial arts competitions in Oregon. The rule amendment implements in Oregon a common industry practice designed to promote the health and safety of competitors, by adding into OAR 230-020-0330 a requirement that female boxing and mixed martial arts competitors submit and pass a pregnancy test in order to participate in the upcoming boxing or mixed martial arts event. The rule includes an option for waiver of the test requirement upon submission of documentation that the contestant has undergone a full hysterectomy. The rule also specifies the timing of the test and acceptable test methods.
Rules Coordinator: Shannon Peterson—(503) 934-0183

230-020-0330
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(ii) The female competitor shall be accompanied to the bathroom facility by the examining physician or authorized female assistant, shall be allowed to take the pregnancy test in privacy, and shall promptly provide the test to the examining physician for interpretation of the results. The female competitor may not carry personal belongings into the bathroom while taking the test.

(c) In place of the pregnancy test described in subsection (b) of this rule, a female competitor may submit a results report from a serum or urine pregnancy test administered within 14 days of the scheduled event by a clinical laboratory or licensed physician. The competitor must submit the results report to the Commission no less than 72 hours before the event.

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Stat. Auth.: ORS 463.113
Stats. Implemented: ORS 463.025 & 463.047
Hist.: BWC 1-1988, f. 3-22-88, cert. ef. 3-29-88; BWC 1-1991, f. & cert. ef. 9-20-91, Section (2) renumbered from 230-060-0150(2); BWC 1-1995, f. 10-10-95, cert. ef. 10-13-95; SAC 5-2008, f. 6-12-08, cert. ef. 7-1-08; SAC 1-2013, f. & cert. ef. 2-21-13; SAC 3-2013(Temp), f. & cert. ef. 7-10-13 thru 1-6-14; SAC 4-2013(Temp), f. & cert. ef. 7-10-13 thru 1-6-14

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Rule Caption: Amends rule to authorize the OSP Superintendent to issue licenses on an annual basis.
Adm. Order No.: SAC 5-2013(Temp)
Filed with Sec. of State: 7-10-2013
Certified to be Effective: 7-10-13 thru 10-12-13
Notice Publication Date:
Rules Amended: 230-020-0002
Subject: Oregon Administrative Rule (OAR) 230-020-0002 sets out that the licensing year for all licenses issued by the Superintendent shall run from July 1 to June 30 of the following year.

It is recommended that Administrative Rule (OAR) 230-020-0002 be amended to authorize the OSP Superintendent to continue issuing licenses on an annual basis and waive the requirement for the licensing year to be constricted from July 1 to June 30th.
Rules Coordinator: Shannon Peterson—(503) 934-0183

230-020-0002
Licensing Year

The OSP Superintendent will issue licenses on an annual basis.

Stat. Auth.: ORS 463.113
Stats. Implemented: ORS 463.025
Hist.: BWC 1-1991, f. & cert. ef. 9-20-91; BWC 1-1995, f. 10-10-95, cert. ef. 10-13-95; SAC 2-2013(Temp), f. & cert. ef. 4-15-13 thru 10-12-13; SAC 5-2013(Temp), f. & cert. ef. 7-10-13 thru 10-12-13

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Department of Public Safety Standards and Training
Chapter 259

Rule Caption: Update timeline for requesting eligibility determination for candidacy for the office of Sheriff. Housekeeping.
Adm. Order No.: DPSST 11-2013
Filed with Sec. of State: 6-24-2013
Certified to be Effective: 6-24-13
Notice Publication Date: 6-1-2013
Rules Amended: 259-008-0075
Subject: All candidates for the office of Sheriff are required by statute to request an eligibility determination from the Department of Public Safety Standards and Training prior to their name appearing on an official ballot. The process is updated to clearly indicate the appropriate steps and order of the steps needed to have an eligibility determination made. Housekeeping changes are also made for clarity.
Rules Coordinator: Linsay Hale—(503) 378-2431

259-008-0075
Eligibility for Candidacy for Office of Sheriff

(1) A person is not eligible to be a candidate for election or appointment to the office of sheriff unless at the time in which an eligibility determination is being requested the person:

(a) Is 21 years of age or older;

(b) Has at least four years experience as a full-time law enforcement officer or at least two years experience as a full-time law enforcement officer with at least two years post-high school education; and

(c) Has not been convicted of a felony or any other crime that would prevent the person from being certified as a police officer under ORS 181.610 to 181.670.

(2) As used in section (1) of this rule, "two years post-high school education" means four semesters or six quarters of classroom education in a formal course of study undertaken after graduation from high school in any accredited college or university. The term does not include apprenticeship or on-the-job training.

(3) The procedure for determining whether an individual is eligible to be a candidate for election to the office of sheriff is:

(a) After filing a nominating petition or declaration of candidacy with the county clerk or county official in charge of elections, a potential candidate for sheriff must submit an Application for Determination of Eligibility to Be Sheriff (DPSST Form F-25) and Criminal History Affidavit (DPSST Form F-26) to the Department;

(b) The Department will make an eligibility determination file a copy of its determination on an individual's eligibility to be a candidate for election to the office of sheriff with the county clerk or county official in charge of elections not later than the 61st day before the date of an election;

(c) The Department will notify the applicant in writing of the determination and decision concerning the eligibility of the applicant by certified mail, mailed to the applicant and postmarked at not later than the 61st day before the date of an election.

(4) If the person is not certified as a police officer by the Department at the time of accepting appointment or filing as a candidate, a person elected or appointed to the office of sheriff must:

(a) Obtain certification not later than one year after taking office;

(b) File a copy of the certification with the County Clerk or the county official in charge of elections within one year after taking office.

(5) Prior to attending any Department-approved training course, a person elected or appointed to the office of Sheriff must comply with the minimum standards for employment and training specified in OAR 259-008-0010 and 259-008-0025. This includes, but is not limited to the following categories:

(a) Citizenship;

(b) Age;

(c) Fingerprints;

(d) Criminal Records;

(e) Notification of Conviction;

(f) Moral Fitness (Professional Fitness);

(g) Education;

(h) Physical Examination:

(A) Any written request for a waiver of any physical requirement must be submitted to the Department as described in OAR 259-008-0010(8)(o);

(B) Any request for a waiver of any physical requirement must be approved by a Policy Committee and Board; and

(C) Any expense associated with providing documentation or testimony shall be borne by the person requesting the waiver.

(i) Submitting an Application for Training (DPSST Form F-5) to the Department providing evidence that a minimum of a 12th grade reading and writing level has been attained, as required in OAR 259-008-0010(7)(c);

(j) Submitting a current Medical Examination Report (DPSST Form F-2) completed by a licensed physician; and

(k) Completion of a Basic Course and Field Training Manual, unless a written request for a waiver of this requirement is received and approved by the Department.

(6) Prior to obtaining certification as a police officer, a person elected or appointed to the office of Sheriff must comply with the minimum standards for certification specified in OAR 259-008-0060 which include, but are not limited to:

(a) Full-time employment;

(b) Submission of a Criminal Justice Code of Ethics (DPSST Form F 11);

(c) Submission of an Application for Certification (DPSST Form F-7) with all applicable sections of the form completed; and

(d) Valid First Aid and cardiopulmonary resuscitation (CPR) cards.

(7) Any newly elected or appointed public safety professional must submit a Personnel Action Report (DPSST Form F-4) to the Department within ten (10) business days after taking office or appointment, as provided in OAR 259-008-0020.

(8) For complete information relating to employment, training and certification requirements, refer to the full text of the statutes and rules referenced in subsections (1) through (6) above.

(9) The Department may deny approval, revoke or rescind any approval previously given if any falsification is made on the application or documents submitted in support of the application.

(10) The Department will provide a copy of this rule to all persons requesting an evaluation of their eligibility to be a candidate for sheriff, upon request.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 206.015
Stats. Implemented: ORS 206.015
Hist.: PS 1-1981, f. 9-26-81, ef. 11-2-81; PS 1-1982, f. & ef. 7-2-82; PS 2-1982, f. & ef. 9-7-82; PS 1-1983, f. & ef. 12-15-83; PS 2-1987, f. & ef. 10-26-87; Renumbered from 259-010-0057, PS 1-1990, f. & cert. ef. 2-7-90; PS 2-1995, f. & cert. ef. 9-27-95; PS 10-1997(Temp), f. & cert. ef. 11-5-97; BPSST 1-1998, f. & cert. ef. 5-6-98; BPSST 2-1998(Temp), f. & cert. ef. 5-6-98 thru 6-30-98; BPSST 3-1998, f. & cert. ef. 6-30-98; DPSST 9-2007, f. & cert. ef. 8-15-07; DPSST 3-2010, f. 4-12-10, cert. ef. 5-1-10; DPSST 11-2013, f. & cert. ef. 6-24-13

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Rule Caption: Correct typographical errors, omissions and ambiguous language.
Adm. Order No.: DPSST 12-2013
Filed with Sec. of State: 6-24-2013
Certified to be Effective: 6-24-13
Notice Publication Date: 6-1-2013
Rules Amended: 259-060-0010, 259-060-0015, 259-060-0020, 259-060-0025, 259-060-0030, 259-060-0060, 259-060-0090, 259-060-0120, 259-060-0135, 259-060-0300, 259-060-0450, 259-060-0500
Subject: Chapter 259, division 60 was reviewed by staff for typographical errors, omissions and ambiguous language. These issues are addressed to provide additional clarification for the private security industry.
Rules Coordinator: Linsay Hale—(503) 378-2431

259-060-0010
Definitions

(1) "Accreditation Program Manager" means a person who is designated as the administrator of an employer accredited training program and is primary liaison with the Department.

(2) "Alarm Monitor" means an individual whose primary duties are the processing of alarms in an alarm monitoring facility.

(3) "Alarm Monitoring Facility" mean any organization, contract or proprietary, with the primary responsibility of reviewing incoming traffic transmitted to alarm receiving equipment and follows up with actions that may include notification of public agencies to address imminent threats related to public safety. This does not include:

(a) Facilities that monitor only production or environmental signals not directly impacting public safety;

(b) Proprietary alarm systems being monitored by Department-certified private security professionals that generate an internal response by another Department-certified private security professional;

(c) Facilities that monitor Personal Emergency Response Systems (PERS) only; or

(d) Facilities utilizing alarms that never generate a response from a public safety agency.

(4) "Applicant" means an individual who is applying for or renewing certification or licensure as a private security provider.

(5) "Armed Private Security Professional" means a private security professional who is certified to possess or has access to a firearm at any time while performing private security services.

(6) "Assessment module" means a Department-approved curriculum given to private security providers that includes, but is not limited to, the demonstration of task-related skills learned in the classroom instruction as applied to hypothetical situations.

(7) "Board" means the Board on Public Safety Standards and Training.

(8) "Certification" means recognition by the Department that a private security professional meets all the qualifications listed in ORS 181.875 and these rules.

(9) "Consideration" means something of value promised, given or done that has the effect of making an agreement to provide private security services.

(10) "De Minimis" means non-monetary compensation received by a volunteer performing private security services for a non-profit organization as defined in ORS 181.871. The compensation may not exceed a fair market value of $125 per day.

(11) "Denial" or "Deny" means the Department's refusal to grant private security certification or issue a license to an applicant who fails to meet the minimum standards for certification or licensure as identified in OAR 259-060-0020, including the mandatory and discretionary disqualifying misconduct identified in OAR 259-060-0300.

(12) "Department" and "DPSST" means the Department of Public Safety Standards and Training.

(13) "Director" means the Director of the Department of Public Safety Standards and Training.

(14) "Employer" means an individual or entity who employs persons to provide private security services.

(15) "Executive Manager" means a person:

(a) Who is authorized to act on behalf of a company or business in matters of licensure and certification;

(b) Who is authorized to hire and terminate personnel;

(c) Whose primary responsibility is the management of certified private security professionals; and

(d) Who has final responsibility for a company's or business's compliance with the ORS 181.870 to 181.991.

(16) "Flagrant Violation" means an act by a provider, contractor, owner or manager who, after being notified of a violation, intentionally continues or repeats the violation within a 36 month period after the initial violation.

(17) "Fundamental" means a duty that is a basic task or function and may be low frequency, but is an essential component of a job.

(18) "Instructor" means any person who has been certified by the Department as meeting the requirements to provide instruction to private security providers or applicants.

(19) "License" means recognition by the Department that executive manager or supervisory manager meets the requirements listed in ORS 181.875 and these rules.

(20) "Policy Committee" means the Private Security and Investigator Policy Committee.

(21) "Primary Responsibility" means an activity that is fundamental to, and required or expected in, the regular course of employment and is not merely incidental to employment.

(22) "Private" as used in the Act means those activities intended for or restricted to the use of a particular person, group or interest, or belonging to or concerning an individual person, company or interest.

(23) "Private Security Professional" means an individual who performs, as the individual's primary responsibility, private security services for consideration, regardless of whether the individual, while performing private security services, is armed or unarmed or wears a uniform or plain clothes, and regardless of whether the individual is employed part-time or full-time to perform private security services.

(24) "Private Security Provider" means any individual who performs the functions of a private security professional, executive manager, supervisory manager or instructor.

(25) "Private Security Services" means the performance of at least one of the following activities:

(a) Observing and reporting unlawful activity;

(b) Preventing or detecting theft or misappropriation of any goods, money or other items of value;

(c) Protecting individuals or property, including, but not limited to proprietary information, from harm or misappropriation;

(d) Controlling access to premises being protected or, with respect to a licensee of the Oregon Liquor Control Commission, controlling access to premises at an entry to the premises or any portion of the premises where minors are prohibited;

(e) Securely moving prisoners;

(f) Taking enforcement action by detaining persons or placing persons under arrest under ORS 133.225; or

(g) Providing canine services for guarding premises or for the detection of unlawful devices or substances.

(26) "Private Security Services Providers Act" or "The Act" means the Private Security Providers Act (ORS Chapter 181.870 through 181.991).

(27) "Revocation" or "Revoke" means action taken by the Department to rescind the certification or licensure of a private security provider who fails to meet the minimum standards for certification or licensure as identified in OAR 259-060-0020, including the mandatory and discretionary disqualifying misconduct identified in OAR 259-060-0300.

(28) "Supervisory Manager" means an employee of or a person supervised by an executive manager who has as a primary responsibility the supervision of certified private security professionals.

(29) "Surrender" means the voluntary relinquishment of private security certification or licensure to the Department.

(30) "Suspension" or "Suspend" means action taken by the Department in temporarily depriving the holder of a license or certificate that authorizes the individual to provide private security services.

(31) "Temporary Work Permit" means a temporary certification or licensure issued by the employer to allow a company to employ and deploy a private security professional, executive or supervisory manager while the application for certification or licensure is being processed. A temporary work permit will not be issued for armed security professionals.

(32) "Unarmed Private Security Professional" means a private security professional who is not in possession of, or has access to, a firearm at any time while performing private security services.

(33) "Violation" means an act or omission that is prohibited under the Act or these rules.

(34) "Withdraw" means action taken by the applicant or private security provider to remove an application from consideration.

Stat. Auth.: ORS 181.870 & 181.878

Stats. Implemented: ORS 181.870 & 181.878

Hist.: PS 9-1997, f. & cert. ef. 8-20-97; PS 10-1997(Temp), f. & cert. ef. 11-5-97; BPSST 1-1998, f. & cert. ef. 5-6-98; BPSST 2-1998(Temp), f. & cert. ef. 5-6-98 thru 6-30-98; BPSST 3-1998, f. & cert. ef. 6-30-98; BPSST 3-1999(Temp), f. & cert. ef. 3-9-99 thru 9-5-99; BPSST 4-1999, f. 4-29-99, cert. ef. 9-5-99; BPSST 3-2000, f. & cert. ef. 8-10-00; BPSST 8-2001(Temp), f. & cert. ef. 8-22-01 thru 2-18-02; BPSST 18-2001(Temp), f. & cert. ef. 11-28-01 thru 2-18-02; BPSST 4-2002(Temp), f. & cert. ef. 2-25-02 thru 7-1-02; BPSST 13-2002, f. & cert. ef. 4-30-02; DPSST 4-2003, f. & cert. ef. 1-22-03; DPSST 11-2005, f. & cert. ef. 10-14-05; DPSST 6-2006, f. & cert. ef. 5-15-06; DPSST 4-2007, f. & cert. ef. 2-15-07; DPSST 11-2007, f. & cert. ef. 10-15-07; DPSST 6-2008, f. & cert. ef. 4-15-08; DPSST 25-2012, f. 10-26-12, cert. ef. 11-1-12; DPSST 28-2012, f. & cert. ef. 12-24-12; DPSST 12-2013, f. & cert. ef. 6-24-13

259-060-0015

Private Security Provider Responsibilities

(1) A person may not act as a private security provider unless that person is certified or licensed under the Private Security Services Providers Act and these rules.

(2)(a) Persons described in ORS 181.871 are exempt from regulation as private security providers.

(b) The exemption found in ORS 181.871(L) does not apply to an individual who has the primary responsibility of controlling access to premises at an entry to the premises or any portion of the premises where minors are prohibited.

(3) Private security providers are prohibited from:

(a) Providing private security services as a private security professional without having a certificate or license issued under the Act and these rules in the person's possession;

(b) Carrying a concealed weapon while providing security services unless currently certified as an armed private security professional and licensed under ORS 166.291; and

(c) Providing training to private security professionals or applicants unless currently certified as an instructor.

(4) For purposes of these administrative rules, these prohibitions apply to any business, employer, or entity that provides private security services within this state regardless of whether the business, employer, or entity is located in this state.

(5) Change of Information.

(a) An applicant or private security provider must notify the Department within 14 calendar days of any change of address by using Form PS-23 (Private Security Services Provider Change of Information).

(b) Executive managers must advise the Department of the hiring or terminations of private security providers using the Form PS-23.

(6) Notification of Arrest. Pursuant to ORS 181.885, any private security provider or applicant who is charged with a crime must notify his or her employer or, if not employed, the Department no later than 48 hours after the charge is filed.

(a) The initial notification may be made by telephone or with a Recent Arrest Form.

(b) The Department may request immediate written notification documenting specific charges, the county and state where any charges are pending, the investigating agency, and the date of arrest.

(7) Should any certified armed private security provider become ineligible to purchase, own or possess a firearm, the provider and the manager, employer or supervisor of the provider must notify the Department in writing within 48 hours of the circumstances causing the ineligibility. The notification must list all facts known and must identify a person whom the Department may contact for additional information.

Stat. Auth.: ORS 181.873, 181.871 & 181.878

Stats. Implemented: ORS 181.873, 181.871 & 181.878

Hist.: PS 9-1997, f. & cert. ef. 8-20-97; PS 10-1997(Temp), f. & cert. ef. 11-5-97; BPSST 1-1998, f. & cert. ef. 5-6-98; BPSST 2-1998(Temp), f. & cert. ef. 5-6-98 thru 6-30-98; BPSST 3-1998, f. & cert. ef. 6-30-98; BPSST 3-1999(Temp), f. & cert. ef. 3-9-99 thru 9-5-99; BPSST 4-1999, f. 4-29-99, cert. ef. 9-5-99; BPSST 3-2000, f. & cert. ef. 8-10-00; BPSST 8-2001(Temp), f. & cert. ef. 8-22-01 thru 2-18-02; BPSST 18-2001(Temp), f. & cert. ef. 11-28-01 thru 2-18-02; BPSST 4-2002(Temp), f. & cert. ef. 2-25-02 thru 7-1-02; BPSST 13-2002, f. & cert. ef. 4-30-02; DPSST 4-2003, f. & cert. ef. 1-22-03; DPSST 11-2005, f. & cert. ef. 10-14-05; DPSST 6-2006, f. & cert. ef. 5-15-06; DPSST 9-2012, f. & cert. ef. 4-2-12; DPSST 25-2012, f. 10-26-12, cert. ef. 11-1-12; DPSST 28-2012, f. & cert. ef. 12-24-12; DPSST 12-2013, f. & cert. ef. 6-24-13

259-060-0020

Minimum Standards for Certification or Licensure

(1) Age. Private security providers must be:

(a) At least 18 years of age to be certified as an unarmed private security professional or licensed supervisory manager; and

(b) At least 21 years of age to be certified as an armed private security professional or instructor or be licensed as an executive manager.

(2) Education.

(a) Applicants for certification or licensure must provide documentary evidence of one of the following:

(A) A high school diploma;

(B) Successful completion of the General Education Development (GED) test; or

(C) A four-year, post-secondary degree issued by an accredited degree-granting college or university recognized by the Oregon Office of Degree Authorization under the provision of ORS 348.604.

(b) Evidence of the above will consist of official transcripts, diplomas, or GED test report forms. Other documentation may be accepted at the discretion of the Department.

(c) Individuals who were certified or licensed on or before November 1, 2012 are exempt from the education requirements identified in subsection (2)(a).

(3) Training. An applicant for certification or licensing must satisfactorily complete the applicable training requirements prescribed by these rules.

(4) Moral Fitness. All private security providers must be of good moral fitness as determined by a criminal background check, department investigation or other reliable sources.

(a) Lack of good moral fitness includes, but is not limited to, mandatory and discretionary disqualifying misconduct as described in OAR 259-060-0300.

(b) For the purposes of this standard, the Department, through the Policy Committee and the Board, has defined core values that are integral to the private security profession. These values are:

(A) Honesty. Honesty includes integrity, credibility, acting honorably and maintaining confidences;

(B) Character. Good character includes being respectful and courteous, being faithful, diligent and loyal to the employer's charge, using discretion, demonstrating compassion and exhibiting courage;

(C) Fair Treatment of Others. Fair treatment of others includes treating others equitably, demonstrating good judgment and not being discriminatory;

(D) Public Trust. Public trust includes maintaining public confidences, being law-abiding and adhering to recognized industry standards; and

(E) Respect for the laws of this state and nation.

(5) Minimum Standards for Armed Certification.

(a) An applicant for certification as an armed private security professional or firearms instructor must not:

(b) Have been committed to the Mental Health and Development Disability Services Division under ORS 426.130, or similar order in another jurisdiction;

(c) Have been found to be mentally ill and subject to an order under ORS 426.130 prohibiting the person from purchasing or possessing a firearm as a result of that mental illness;

(d) Be prohibited under US Code Title 18, Section 922(g)(8) (relating to civil restraining orders including stalking or harassment) from possessing a firearm in interstate commerce; or

(e) Be prohibited under any law of this state or any federal law from purchasing, owning or possessing a firearm.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 181.875, 181.878 & 181.883

Stats. Implemented: ORS 181.875 & 181.878

Hist.: PS 9-1997, f. & cert. ef. 8-20-97; PS 10-1997(Temp), f. & cert. ef. 11-5-97; BPSST 1-1998, f. & cert. ef. 5-6-98; BPSST 2-1998(Temp), f. & cert. ef. 5-6-98 thru 6-30-98; BPSST 3-1998, f. & cert. ef. 6-30-98; BPSST 3-1999(Temp), f. & cert. ef. 3-9-99 thru 9-5-99; BPSST 4-1999, f. 4-29-99, cert. ef. 9-5-99; BPSST 3-2000, f. & cert. ef. 8-10-00; BPSST 8-2001(Temp), f. & cert. ef. 8-22-01 thru 2-18-02; BPSST 18-2001(Temp), f. & cert. ef. 11-28-01 thru 2-18-02; BPSST 4-2002(Temp), f. & cert. ef. 2-25-02 thru 7-1-02; BPSST 13-2002, f. & cert. ef. 4-30-02; DPSST 10-2003(Temp), f. & cert. ef. 6-16-03 thru 12-1-03; DPSST 12-2003, f. & cert. ef. 7-24-03; DPSST 6-2004, f. & cert. ef. 4-23-04; DPSST 9-2005, f. & cert. ef. 10-14-05; DPSST 6-2006, f. & cert. ef. 5-15-06; DPSST 19-2008, f. & cert. ef. 10-15-08; DPSST 25-2012, f. 10-26-12, cert. ef. 11-1-12; DPSST 12-2013, f. & cert. ef. 6-24-13

259-060-0025

Application for Certification and Licensure

(1) An applicant must meet all minimum standards for the certification or license being applied for as described in OAR 259-060-0020.

(2) Application Packet and Fees.

(a) The application packet for new certification or licensure as a private security provider must be completed in its entirety and must include:

(A) A completed Form PS-1 (Application for Licensure or Certification of Private Security Services Provider);

(B) A completed fingerprint packet. A fingerprint packet must include a pre-printed FBI fingerprint card and a Form PS-4 (Affidavit of Person Rolling Fingerprints) completed by the person rolling or scanning the fingerprints. The card and form must be enclosed in a tamper-proof bag and sealed by the person who rolled the fingerprints before the packet is returned to the applicant. The Department will supply pre-printed FBI fingerprint cards and tamper-proof bags.

(i) The Department will only accept fingerprint cards correctly rolled and completed by private security or public safety personnel trained to roll fingerprints, or a person who is employed and trained by a private business that provides fingerprinting services.

(ii) If a fingerprint card is rejected twice by the Federal Bureau of Investigation, the applicant will be charged a fee for a third submittal of fingerprint cards.

(C) The original Form PS-6 (Affidavit of Instructor and Private Security Provider Testing Results) completed as prescribed by OAR 259-060-0060, documenting completion of the training required in these rules. Applicants enrolled in an accredited private security program at the time of application will submit the Form PS-6 upon completion of the program.

(D) A completed Form PS-7 (Private Security Instructor Evaluation) (optional);

(E) If currently employed, an original, completed Form PS-20 (Private Security Services Provider Temporary Work Permit). Temporary Work Permits will not be issued to armed private security professionals or private security instructors;

(F) A completed Form PS-27 (Private Security Professional Code of Ethics) affirming moral fitness and professional standards;

(G) All applicants for instructor certification must submit a resume demonstrating they meet the instructor prerequisites as described in OAR 259-060-0135; and

(H) Nonrefundable certification or licensure fees as prescribed by OAR 259-060-0500.

(b) The application packet for renewing certification or licensure as a private security provider must be completed in its entirety and must include:

(A) A completed Form PS-21 (Application for Renewal of Private Security Certification/Licensure);

(B) A completed Form PS-27 affirming moral fitness and professional standards;

(C) The original Form PS-6 completed as prescribed by OAR 259-060-0060, documenting completion of the training required in these rules. Applicants enrolled in an accredited private security program at the time of application will submit the Form PS-6 upon completion of the program.

(D) All applicants for renewal of instructor certification must submit a Form PS-8 (Private Security Instructor Continuing Education);

(E) A Form PS-20 if currently employed and submitting the renewal packet less than 30 days prior to the expiration of certification or licensure; and

(F) Nonrefundable renewal certification or licensure fees as prescribed by OAR 259-060-0500;

(c) The application packet for adding certification or licensure as a private security provider must be completed in its entirety and must include:

(A) A completed Form PS-1;

(B) The original Form PS-6 completed as prescribed by OAR 259-060-0060, documenting completion of the training required in these rules. Applicants enrolled in an accredited private security program at the time of application will submit the Form PS-6 upon completion of the program.

(C) If currently employed, an original, completed Form PS-20. Temporary Work Permits will not be issued to armed private security professionals or private security instructors;

(D) A completed Form PS-27 affirming moral fitness and professional standards;

(E) Nonrefundable certification or licensure fees as prescribed by OAR 259-060-0500;

(F) Individuals applying to add private security instructor certification must submit a resume demonstrating they meet the instructor prerequisites as described in OAR 259-060-0135.

(G) Individuals currently certified as an unarmed private security provider applying to add armed private security certification must carry a copy of the Form PS-6 and the Form PS-23 (Change of Information) while performing private security services until a new certificate is received.

(d) The application packet for upgrading from unarmed private security professional to an armed private security professional must be completed in its entirety and must include:

(A) A completed Form PS-1;

(B) The original Form PS-6 completed as prescribed by OAR 259-060-0060, documenting completion of the training required in these rules. Applicants enrolled in an accredited private security program at the time of application will submit the Form PS-6 upon completion of the program. ;

(C) A completed Form PS-27 affirming moral fitness and professional standards; and

(D) Nonrefundable certification or licensure fees as prescribed by OAR 259-060-0500;

(E) Individuals currently certified as an unarmed private security provider applying to upgrade to armed private security certification must carry a copy of the Form PS-6 and the Form PS-23 (Change of Information) while performing private security services until a new certificate is received.

(3) Timelines.

(a) A completed application packet must be mailed to the Department and postmarked prior to the applicant performing any private security services.

(b) Renewal application documents must be received by the Department within 180 days prior to the expiration date of the certification or licensure to allow for processing of the forms and criminal history check.

(c) A late submission penalty will be assessed as prescribed in OAR 259-060-0500 if reapplying after the expiration date of the certification or licensure.

(d) Applicants renewing their certification or licensure more than four years after the expiration date of the certification or licensure must submit a new application packet in accordance with subsection (2)(a) of this rule.

(4) The Department may administratively terminate the application process if the Department is unable to complete the certification process due to non-response or non-compliance, or upon the discovery of disqualifying criminal convictions or any violation of the temporary work permit provisions, the Act or these rules.

(a) Once the application process has been administratively terminated, the applicant may not perform private security services.

(b) To re-apply, applicants will be required to re-submit an application packet with all deficiencies corrected, including new fees and proof of valid training.

(5) A Notice of Deficiency will be issued to an applicant whose application packet is determined by the Department to be incomplete or insufficient. If the deficiency is not corrected within 21 days of the date of the Notice of Deficiency, the application process will be administratively terminated.

(6) Any exception to the application process found in this rule must be approved by the Department.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 181.873 - 181.878 & 181.883 - 181.885

Stats. Implemented: ORS 181.873 - 181.878 & 181.883 - 181.885

Hist.: DPSST 25-2012, f. 10-26-12, cert. ef. 11-1-12; DPSST 12-2013, f. & cert. ef. 6-24-13

259-060-0030

Temporary Assignments

(1) Temporary Work Permits. Employing, licensed managers may issue Temporary Work Permits to private security providers upon verification that all application requirements have been completed.

(a) Temporary work permits must be requested on a Form PS-20 (Temporary Work Permit). The Form PS-20 is a three-page document which requires an original signature on all three pages.

(A) The appropriate portion of the Form PS-20 must be mailed to the Department and must be postmarked on or before the first day the applicant performs private security services.

(B) The appropriate copy of the Form PS-20 must be retained by the employer and employee and kept on his person at all times while providing security services in the state of Oregon or while on duty.

(C) The employee's copy must be presented to any DPSST staff member, law enforcement officer or Oregon Liquor Control Commission agent upon demand or any other person upon reasonable request.

(b) Temporary Work Permits may be held for up to 120 days.

(c) Employing, licensed managers may only issue one Temporary Work Permit per employee. Upon expiration of a Temporary Work Permit, subsequent Temporary Work Permits may be issued by contacting the Department and receiving approval.

(d) An employing, licensed manager may replace a Temporary Work Permit that has been lost or destroyed.

(e) Temporary work permits may not be issued to armed private security professionals or instructors.

(f) Managers may self-issue a temporary work permit upon completion of all application requirements.

(g) The Department may, upon written notice, administratively terminate a Temporary Work Permit for the following reasons:

(A) The Department has reason to believe that a person with the applicant's name and birth date fails to meet the minimum moral fitness standards as described in OAR 259-060-0020 and 259-060-0300;

(B) An application is incomplete or the Department has been unable to verify application information to its satisfaction due to non-response or non-compliance of the applicant; or

(C) The holder of the Temporary Work Permit has violated any provisions of the Temporary Work Permit, the Act or these administrative rules.

(h) Upon notification from the Department that the Temporary Work Permit has been administratively terminated, the applicant may not perform private security services.

(i) A new application packet, including all required fees and proof of valid training, must be submitted as prescribed in OAR 259-060-0025 prior to the issuance of a new Temporary Work Permit.

(2) Reciprocity.

(a) As prescribed by ORS 181.873(2), an employing, licensed executive manager may temporarily assign a person who is not certified as a private security professional in the state of Oregon to perform private security services in this state for a period of time not to exceed 90 days if:

(A) The person is employed in another state;

(B) The person holds a private security professional's certification or license from another state; and

(C) The certification or licensing standards of the other state meet or exceed the standards of this state.

(b) Reciprocity must be requested on a Form PS-9 (Private Security Waiver for Reciprocity.) The Form PS-9 is a triplicate form.

(A) The appropriate portion of the Form PS-9 must be mailed to the Department and must be postmarked on or before the first day the applicant performs private security services.

(B) The appropriate copy of the Form PS-9 must be retained by the employer and employee and kept on his person at all times while providing security services in the state of Oregon or while on duty.

(C) The employee's copy must be presented to any DPSST staff member, law enforcement officer or Oregon Liquor Control Commission agent upon demand or any other person upon reasonable request.

(c) Only one Form PS-9 will be authorized per private security provider in a 24-month period. Additional Form PS-9's may be issued by contacting the Department and receiving approval prior to the issuance of the PS-9.

Stat. Auth.: ORS 181.873 - 181.878 & 181.883 - 181.885
Stats. Implemented: ORS 181.873 - 181.878 & 181.883 - 181.885
Hist.: DPSST 25-2012, f. 10-26-12, cert. ef. 11-1-12; DPSST 12-2013, f. & cert. ef. 6-24-13

259-060-0060
Minimum Standards for Training

(1) All private security courses and examinations will be based upon a curriculum approved by the Board.

(2) All required training and testing must be conducted by a certified private security instructor as defined in OAR 259-060-0010 or by a Department designee.

(3) All required firearms courses must be administered by a certified private security firearms instructor.

(4) Only the Department or a designee will deliver instructor courses, firearms private security instructor courses and manager courses.

(5) All training must be delivered in English and assessments and written exams must be completed in English, without assistance.

(6) The Department website will provide names of instructors who have requested on a Department-approved form that their names be available to applicants.

(7) Only a certified private security instructor delivering the training on-site may sign a Form PS-6 (Affidavit of Instructor and Private Security Provider Testing Results).

(8) It is the responsibility of the applicant or private security provider to submit the original Form PS-6 to the Department upon completion of courses as specified in these rules. The Form PS-6 must be signed by the certified instructor who administered the course and enclosed in a tamper-proof bag, sealed by the instructor.

(9) To satisfy the training requirements for private security certification or licensure, training must be submitted to the Department within 180 days of the training being completed.

(10) Private Security Course Descriptions.

(a) Basic Classroom Instruction. Basic classroom consists of live classroom instruction which may include use of a subject matter expert, audio and visual instruction. Instructors must provide individuals with a manual of the basic curriculum. Applicants must complete a closed-book written examination.

(b) Assessment Module. The assessment module is a hands-on, practical exercise given to private security professionals that will reinforce the knowledge and techniques presented during classroom instruction. The module consists of evaluation and includes, but is not limited to, scenarios requiring application of task-related skills learned in the basic classroom instruction.

(c) Basic Firearms Course. Basic Firearms course must include:

(A) A minimum of 24 hours of instruction and an open-book written examination covering firearms instruction materials;

(B) A safe gun handling test; and

(C) A marksmanship qualification using firearms qualification standards and targets.

(d) Instructor Course. The instructor course teaches curriculum, instructing techniques, and Department policies and procedures. The course includes classroom instruction, an assessment module and a written examination. Instructor applicants must use a Board-approved manual to review the course in a self-study environment; and

(e) Firearms Private Security Instructor Course. The firearms private security instructor course teaches armed professional curriculum instruction, instructing techniques, practical application and Department policies and procedures. The course includes classroom instruction, marksmanship qualification, safe handgun handling and a written examination. Instructor applicants must use a Board-approved manual to review the course in a self-study environment.

(f) Manager Course. The manager course trains on Department policies and procedures. The course includes classroom instruction, an assessment module and a written examination. Private security manager applicants must use a Board-approved manual to review the training in a self-study environment.

(11) Private Security Certification and Licensure Maintenance Course Descriptions.

(a) Annual Firearms Marksmanship Requalification and Refresher Course includes an annual firearms marksmanship requalification and the annual armed 4-hour classroom refresher course and closed-book written examination.

(b) Biennial Renewal Training includes a four-hour biennial renewal course related to the current level of certification and in accordance with OAR 259-060-0120, 259-060-0130, and 259-060-0135.

(c) Annual Firearms Instructor Marksmanship Qualification includes an annual firearms marksmanship requalification.

(12) Applicants must achieve a score of 100 percent on all examinations and assessments with remediation in accordance with OAR 259-060-0135(8).

(13) All private security providers who have previously been certified or licensed by the Department as a private security provider whose certification or licensure has been expired for over four years from must reapply and complete all required training again in accordance with OAR 259-060-0025(2)(a).

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 181.878 & 181.883
Stats. Implemented: ORS 181.878
Hist.: PS 9-1997, f. & cert. ef. 8-20-97; PS 10-1997(Temp), f. & cert. ef. 11-5-97; BPSST 1-1998, f. & cert. ef. 5-6-98; BPSST 2-1998(Temp), f. & cert. ef. 5-6-98 thru 6-30-98; BPSST 3-1998, f. & cert. ef. 6-30-98; BPSST 3-1999(Temp), f. & cert. ef. 3-9-99 thru 9-5-99; BPSST 4-1999, f. 4-29-99, cert. ef. 9-5-99; BPSST 3-2000, f. & cert. ef. 8-10-00; BPSST 8-2001(Temp), f. & cert. ef. 8-22-01 thru 2-18-02; BPSST 18-2001(Temp), f. & cert. ef. 11-28-01 thru 2-18-02; BPSST 4-2002(Temp), f. & cert. ef. 2-25-02 thru 7-1-02; BPSST 13-2002, f. & cert. ef. 4-30-02; DPSST 6-2006, f. & cert. ef. 5-15-06; DPSST 4-2007, f. & cert. ef. 2-15-07; DPSST 6-2008, f. & cert. ef. 4-15-08; DPSST 25-2012, f. 10-26-12, cert. ef. 11-1-12; DPSST 12-2013, f. & cert. ef. 6-24-13

259-060-0090
Challenge of Alarm Monitor Classroom Instruction and Assessment Module

(1) At the discretion of the Department, an applicant for alarm monitor supervisory manager licensure, alarm monitor executive manager licensure, or alarm monitor instructor certification employed outside the state of Oregon may challenge the basic classroom instruction training requirement described in these rules if the person has three or more years experience in the field of alarm monitoring.

(a) The applicant will only be given one opportunity to challenge the basic classroom instruction course by successfully completing the required written examination administered by the Department or designee in accordance with these rules.

(b) Failure to obtain a passing score on the challenged examination will require attendance at a basic classroom instruction course and successful completion of the examination.

(2) The Department may waive the assessment module training requirement for alarm monitor instructor certification for applicants with three or more years experience instructing in the field of alarm monitoring.

Stat. Auth.: ORS 181.878 & 181.883
Stats. Implemented: ORS 181.878 & 181.883
Hist.: PS 9-1997, f. & cert. ef. 8-20-97; PS 10-1997(Temp), f. & cert. ef. 11-5-97; BPSST 1-1998, f. & cert. ef. 5-6-98; BPSST 2-1998(Temp), f. & cert. ef. 5-6-98 thru 6-30-98; BPSST 3-1998, f. & cert. ef. 6-30-98; BPSST 3-1999(Temp), f. & cert. ef. 3-9-99 thru 9-5-99; BPSST 4-1999, f. 4-29-99, cert. ef. 9-5-99; BPSST 3-2000, f. & cert. ef. 8-10-00; BPSST 8-2001(Temp), f. & cert. ef. 8-22-01 thru 2-18-02; BPSST 18-2001(Temp), f. & cert. ef. 11-28-01 thru 2-18-02; BPSST 4-2002(Temp), f. & cert. ef. 2-25-02 thru 7-1-02; BPSST 13-2002, f. & cert. ef. 4-30-02; DPSST 6-2006, f. & cert. ef. 5-15-06; DPSST 11-2007, f. & cert. ef. 10-15-07; DPSST 25-2012, f. 10-26-12, cert. ef. 11-1-12; DPSST 12-2013, f. & cert. ef. 6-24-13

259-060-0120
Private Security Professional Certification and Responsibilities

(1) All private security professional applicants must complete an application in accordance with OAR 259-060-0025.

(2) All private security professionals must be in compliance with the minimum standards for certification as listed in OAR 259-060-0020.

(3) Alarm Monitor Private Security Professional.

(a) A certified private security alarm monitor professional is authorized to perform the duties defined in OAR 259-060-0010.

(b) Basic training consists of successful completion of eight hours of alarm monitor basic classroom instruction and exam and a four-hour alarm monitor assessment.

(c) Biennial alarm monitor renewal training consists of a four-hour alarm monitor renewal course and exam.

(4) Unarmed Private Security Professional.

(a) A certified unarmed private security professional is authorized to perform the duties defined in OAR 259-060-0010.

(b) Basic training consists of successful completion of eight hours of unarmed basic classroom instruction and exam and a four-hour unarmed assessment.

(c) Biennial unarmed renewal training consists of a four-hour unarmed renewal course and exam.

(5) Armed Private Security Professional.

(a) A certified armed private security professional is authorized to perform the duties defined in OAR 259-060-0010.

(b) In addition to the minimum standards for unarmed certification, armed professionals must also be in compliance with the firearms standards listed in OAR 259-060-0020.

(c) Basic training consists of successful completion of:

(A) Eight hours of unarmed basic classroom instruction, exam and four-hour unarmed assessment; and

(B) Basic firearms course as defined in OAR 259-060-0060 which consists of a minimum 24 hours of basic armed instruction, a written examination, safe gun handling test and marksmanship qualification.

(d) Armed annual refresher course consists of a minimum of four hours including the armed refresher course and exam and firearms marksmanship requalification.

(e) In addition to the annual refresher course, armed private security professionals must complete an unarmed renewal training biennially.

(6) Department-accredited courses may satisfy the training requirements listed above.

(7) Failure to complete any training requirements as prescribed by this rule may result in denial or revocation of private security certification or licensure as prescribed in OAR 259-060-0300 and civil penalties as prescribed in OAR 259-060-0450.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 181.873 - 181.878 & 181.883 - 181.885

Stats. Implemented: ORS 181.873 - 181.878 & 181.883 - 181.885

Hist.: PS 9-1997, f. & cert. ef. 8-20-97; PS 10-1997(Temp), f. & cert. ef. 11-5-97; BPSST 1-1998, f. & cert. ef. 5-6-98; BPSST 2-1998(Temp), f. & cert. ef. 5-6-98 thru 6-30-98; BPSST 3-1998, f. & cert. ef. 6-30-98; BPSST 3-1999(Temp), f. & cert. ef. 3-9-99 thru 9-5-99; BPSST 4-1999, f. 4-29-99, cert. ef. 9-5-99; BPSST 3-2000, f. & cert. ef. 8-10-00; BPSST 8-2001(Temp), f. & cert. ef. 8-22-01 thru 2-18-02; BPSST 18-2001(Temp), f. & cert. ef. 11-28-01 thru 2-18-02; BPSST 4-2002(Temp), f. & cert. ef. 2-25-02 thru 7-1-02; BPSST 13-2002, f. & cert. ef. 4-30-02; DPSST 4-2003, f. & cert. ef. 1-22-03; DPSST 3-2005(Temp), f. 4-25-05, cert. ef. 5-1-05 thru 10-28-05; DPSST 9-2005, f. & cert. ef. 10-14-05; DPSST 6-2006, f. & cert. ef. 5-15-06; DPSST 4-2007, f. & cert. ef. 2-15-07; DPSST 6-2008, f. & cert. ef. 4-15-08; DPSST 25-2012, f. 10-26-12, cert. ef. 11-1-12; DPSST 12-2013, f. & cert. ef. 6-24-13

259-060-0135

Private Security Instructor Certification and Responsibilities

(1) The Department will certify instructors deemed qualified to instruct any required private security professional training courses.

(2) All private security instructor applicants must complete an application in accordance with OAR 259-060-0025.

(3) All private security instructor applicants must be in compliance with the minimum standards for certification as listed in OAR 259-060-0020. In addition, applicants must:

(a) Have a minimum three years of work experience in private security services, military police, or law enforcement fields; and

(b) Applicants for certification as a firearms private security instructor must be in compliance with the firearms standards listed in OAR 259-060-0020.

(4) Private security instructors are authorized to instruct and deliver private security professional courses based on the approved or accredited private security professional course content and materials provided by the Department.

(a) Private security instructors must remediate or fail applicants as necessary.

(b) Private security instructors must provide all applicants with appropriate training manuals.

(c) Only a certified private security instructor delivering the training on-site may sign a Form PS-6 (Affidavit of Instructor and Private Security Provider Testing Results).

(d) Certified private security instructors are responsible for verifying the identity of all applicants using government-issued identification.

(e) Only private security firearms instructors are authorized to instruct and administer basic and renewal firearms courses.

(f) All private security instructors must instruct courses in a manner that is consistent with the minimum requirements of the Department, including safety provisions. Training facilities must be an environment conducive to learning.

(5) Alarm monitor private security instructor.

(a) Basic training consists of the successful completion of:

(A) Alarm monitor basic classroom instruction and exam;

(B) Alarm monitor assessment; and

(C) Alarm monitor private security instructor course.

(b) Biennial alarm monitor private security instructor renewal training consists of the successful completion of:

(A) Alarm monitor private security instructor course; and

(B) A minimum of eight hours of coursework relating to any of the specific subjects being taught or a minimum of eight hours of coursework relating to improving instructor skills.

(6) Unarmed private security instructor.

(a) Basic training consists of the successful completion of:

(A) Unarmed basic classroom instruction and exam;

(B) Unarmed assessment; and

(C) Unarmed private security instructor course and exam.

(b) Biennial unarmed private security instructor renewal training consists of the successful completion of:

(A) Unarmed private security instructor course and exam; and

(B) A minimum of eight hour of coursework relating to any of the specific subjects being taught or a minimum of eight hours of coursework relating to improving instructor skills.

(7) Firearms Private Security Instructor.

(a) Basic training consists of the successful completion of:

(A) Basic unarmed classroom instruction and exam;

(B) Basic unarmed assessment;

(C) Basic firearms course;

(D) Department-administered firearms private security instructor course and Department-approved marksmanship qualification; and

(E) Proof of successful completion of training from one or more of the following sources no more than five years prior to the time of application:

(i) The National Rifle Association Law Enforcement Firearms Instructor Development School;

(ii) A firearms instructor through the Federal Law Enforcement Training Center;

(iii) A Department-certified law enforcement or criminal justice firearms instructor course;

(iv) A firearms instructor through the Federal Bureau of Investigation;

(v) A private security firearms instructor through the Washington Criminal Justice Training Center; or

(vi) A qualified instructor certification course as determined by the Department.

(b) Firearms private security instructors must successfully complete annual firearms instructor marksmanship qualifications. Instructors must qualify on a target authorized by the Department, within three attempts in one day.

(c) Biennial renewal consists of :

(A) Successful completion of the firearms private security instructor course, written exam, and marksmanship qualifications.; and

(B) A minimum of eight hours of coursework relating to any of the specific subjects being taught or a minimum of eight hours of coursework relating to improving instructor skills.

(8) Certified private security instructors who simultaneously hold certification as a private security professional are exempt from the required private security professional renewal training if they deliver the basic curriculum of the discipline for which they are certified at least one time per year.

(9) Applicant Remediation/Failure. When an applicant fails to successfully complete any portion of the required training the instructor must remediate or fail the applicant as follows:

(a) If a test score is between 85 and 99 percent, the instructor must remediate the incorrect test responses by reviewing each incorrect test question with the applicant, explaining the principle behind the question, the correct answer, and the basis for the correct answer. The instructor must assess whether oral responses from the applicant indicate that the applicant understands the underlying principles. An inappropriate answer may result in the termination of training and indication on the training affidavit that the applicant has failed to successfully complete the required training.

(b) If a test score is below 85 percent correct, the instructor must fail the applicant or require the applicant repeat the deficient section missed of the curriculum and retake the exam.

(c) The instructor may remediate and re-test an applicant who fails to score 100% on the firearms marksmanship qualification course. Re-qualification attempts are limited to three in a single session.

(d) An applicant who is unable to successfully achieve a training standard must be failed. Any instructor who fails an applicant must:

(A) Fully document the reason for failure;

(B) Retain documentation of failure in the instructor's file for a minimum period of two years; and

(C) Notify the Department within 48 hours of the failure by submitting a Form PS-6 indicating that an individual has failed.

(10) Instructors may terminate training if, in the instructor's opinion, the applicant is unfit to proceed, taking into consideration the applicant's poor judgment, unsafe practices, abnormal behavior or other relevant factors. The instructor must immediately notify the applicant of the reason for termination of training and must also notify the Department within 48 hours in writing, using a Form PS-6.

(11) Training Records.

(a) Instructors must maintain the following documents in separate class files for a period of two years:

(A) A Form PS-6 (Affidavit of Instructor and Private Security Provider Testing Results) for each applicant;

(B) All written exams, assessments and any applicable qualification records;

(C) A training outline for the curriculum used, including any references to any resources used; and

(D) A class roster, including the name and address of each applicant.

(b) Upon successful completion of all requirements, the instructor must provide the applicant the accurately-completed, original Form PS-6, sealed in a tamper-proof bag. The instructor will also supply the applicant with a colored carbon copy of the Form PS-6.

(c) Instructors will provide additional copies of the Form PS-6 to applicants at any time during the life of their training at reasonable expense to the applicant.

(12) Failure to complete any training requirements as prescribed by this rule may result in denial or revocation or private security certification or licensure as prescribed in OAR 259-060-0300 and civil penalties as prescribed in OAR 259-060-0450.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 181.878 & 181.883

Stats. Implemented: ORS 181.878

Hist.: PS 9-1997, f. & cert. ef. 8-20-97; PS 10-1997(Temp), f. & cert. ef. 11-5-97; BPSST 1-1998, f. & cert. ef. 5-6-98; BPSST 2-1998(Temp), f. & cert. ef. 5-6-98 thru 6-30-98; BPSST 3-1998, f. & cert. ef. 6-30-98; BPSST 3-1999(Temp), f. & cert. ef. 3-9-99 thru 9-5-99; BPSST 4-1999, f. 4-29-99, cert. ef. 9-5-99; BPSST 3-2000, f. & cert. ef. 8-10-00; BPSST 8-2001(Temp), f. & cert. ef. 8-22-01 thru 2-18-02; BPSST 18-2001(Temp), f. & cert. ef. 11-28-01 thru 2-18-02; BPSST 4-2002(Temp), f. & cert. ef. 2-25-02 thru 7-1-02; BPSST 13-2002, f. & cert. ef. 4-30-02; DPSST 11-2005, f. & cert. ef. 10-14-05; DPSST 6-2006, f. & cert. ef. 5-15-06; DPSST 4-2007, f. & cert. ef. 2-15-07; DPSST 6-2008, f. & cert. ef. 4-15-08; DPSST 25-2012, f. 10-26-12, cert. ef. 11-1-12; DPSST 12-2013, f. & cert. ef. 6-24-13

259-060-0300
Denial/Suspension/Revocation

(1) It is the responsibility of the Board, through the Private Security and Investigator Policy Committee, to set the standards, and of the Department to uphold them, to ensure the highest level of professionalism and discipline. The Board will uphold these standards at all times unless the Board determines that neither the safety of the public or respect of the profession is compromised. Mandatory Grounds for Denying, Suspending or Revoking Private Security Certification or Licensure

(2) The Department must deny or revoke a certification or license of any applicant or private security provider after written notice and hearing, if requested, upon a finding that the applicant or private security provider:

(a) Has been convicted of a person felony as defined by the Criminal Justice Commission in OAR 213-003-0001 in effect on April 27, 2012 or any crime with similar elements in any other jurisdiction;

(b) Is required to register as a sex offender under ORS 181.595, 181.596, 181.597 or 181.609; or

(c) Has, within a period of ten years prior to application or during certification or licensure, been convicted of the following:

(A) Any felony other than those described in subsection (a) above or any crime with similar elements in any other jurisdiction;

(B) A person class A misdemeanor as defined by the Criminal Justice Commission in OAR 213-003-0001 in effect on April 27, 2012 or any crime with similar elements in any other jurisdiction;

(C) Any crime involving any act of domestic violence as defined in ORS 135.230 or any crime with similar elements in any other jurisdiction;

(D) Any misdemeanor or felony conviction involving the unlawful use, possession, delivery or manufacture of a controlled substance, narcotic, or dangerous drug in this or any other jurisdiction;

(E) Any misdemeanor arising from conduct while on duty as a private security provider; or

(F) Any of the following misdemeanors:

161.405(2)(d) (Attempt to Commit a Class C Felony or Unclassified Felony)
161.435(2)(d) (Solicitation of a Class C Felony)
161.450(2)(d) (Conspiracy to Commit a Class A misdemeanor)
162.075 (False Swearing)
162.085 (Unsworn Falsification)
162.145 (Escape III)
162.235 (Obstructing Governmental or Judicial Administration)
162.247 (Interfering with a Peace Officer)
162.295 (Tampering with Physical Evidence)
162.335 (Compounding a Felony)
162.365 (Criminal Impersonation)
162.369 (Possession of a False Law Enforcement Identification Card)
162.375 (Initiating a False Report)
162.385 (Giving False Information to Police Officer for a Citation or Arrest on a Warrant)
162.415 (Official Misconduct I)
163.435 (Contributing to the Sexual Delinquency of a Minor)
164.043 (Theft III)
164.045 (Theft II)
164.125 (Theft of Services)
164.140 (Criminal Possession of Rented or Leased Personal Property)
164.235 (Possession of Burglar's Tools)
164.255 (Criminal Trespass I)
164.265 (Criminal Trespass while in Possession of a Firearm)
164.335 (Reckless Burning)
164.354 (Criminal Mischief II)
164.369 (Interfering with Police Animal)
164.377(4) (Computer Crime)
165.007 (Forgery II)
165.055(4)(a) (Fraudulent Use of a Credit Card)
165.065 (Negotiating a Bad Check)
165.570 (Improper Use of Emergency Reporting System)
166.115 (Interfering with Public Transportation)
166.240 (Carrying of Concealed Weapons)
166.250 (Unlawful Possession of Firearms)
166.350 (Unlawful Possession of Armor Piercing Ammunition)
166.425 (Unlawful Purchase of Firearm)
167.007 (Prostitution)
167.062 (Sadomasochistic Abuse or Sexual Conduct in a Live Show)
167.075 (Exhibiting an Obscene Performance to a Minor)
167.080 (Displaying Obscene Material to Minors)
167.262 (Adult Using Minor in Commission of Controlled Substance Offense)
167.320 (Animal Abuse I)
167.330 (Animal Neglect I)
471.410 (Providing Liquor to a Person Under 21 or Intoxicated Person)
807.620 (Giving False Information to a Police Officer/Traffic)
811.540(3)(b) (Fleeing or Attempting to Elude Police Officer) Any crime with similar elements in any other jurisdiction.

(3) Emergency Suspension Order: The Department may issue an emergency suspension order pursuant to OAR 137-003-0560 immediately suspending a private security provider's certification or licensure upon finding that a person has been charged with any of the mandatory disqualifying crimes listed in section (2) of this rule. The report may be in any form and from any source.

(a) The Department may combine the hearing on the Emergency Suspension Order with any underlying proceeding affecting the license or certificate.

(b) The sole purpose of the emergency suspension hearing will be to determine whether the individual was charged with a mandatory disqualifying crime. Upon showing that an individual was not charged with a mandatory disqualifying crime, the suspension of the individual's certification or licensure will be rescinded, otherwise the suspension will remain in effect until final disposition of the charges. Discretionary Grounds for Denying, Suspending or Revoking Private Security Certification or Licensure

(4) The Department may deny or revoke the certification or licensure of any applicant or private security provider after written notice and hearing, if requested, upon finding that an applicant or private security provider:

(a) Fails to meet the minimum standards for certification or licensure as a private security provider as defined in OAR 259-060-0020;

(b) Has falsified any information submitted on the application for certification or licensure or any documents submitted to the Department pertaining to private security certification or licensure;

(c) Has violated any of the temporary assignment provisions of OAR 259-060-0120(1);

(d) Has failed to submit properly completed forms or documentation in a time frame as designated by the Department;

(e) Has failed to pay a civil penalty or fee imposed by the Department when due;

(f) Has failed to comply with any provisions found in the Act or these rules; or

(g) Lacks moral fitness. For the purposes of this standard, the Department, through the Policy Committee and Board, has defined lack of moral fitness as:

(A) Dishonesty. Lack of honesty includes, but is not limited to, untruthfulness, dishonesty by admission or omission, deception, misrepresentation or falsification;

(B) Lack of Good Character. Lack of good character includes, but is not limited to, failure to be faithful and loyal to the employer's charge and failure to use discretion and compassion;

(C) Mistreatment of Others. Mistreatment of others includes, but is not limited to, violating another person's rights and failure to respect others;

(D) Lack of Public Trust. Failure to maintain public trust and confidence includes, but is not limited to, acting in an unlawful manner or not adhering to recognized industry standards; or

(E) Lack of Respect for the Laws of this State or Nation. Lack of respect for the laws of this state and nation includes a pattern of behavior which leads to three or more arrests or convictions within a ten-year period prior to application or during certification or licensure. Procedure for Denial or Revocation of Certification or Licensure

(5) Scope of Revocation. Whenever the Department revokes the certification or licensure of a private security provider under the provisions of this rule, the revocation will encompass all private security certificates and licenses the Department has issued to that person.

(6) Denial and Revocation Procedure.

(a) Employer Request: When the employer of the private security provider requests that certification or licensure be denied or revoked, the employer must submit in writing to the Department the reason for the requested action and include all factual information supporting the request.

(b) Department Initiated Review: Upon receipt of factual written information from any source other than an employer, and pursuant to ORS 181.878, the Department may request that the Board deny, revoke or suspend the private security provider's certification or licensure.

(c) Department Staff Review:

(A) When the Department receives information, from any source, that a private security provider may not meet the established standards for Oregon private security providers, the Department will review the request and the supporting factual information to determine if a sufficient factual basis exists to support the request for denial, suspension, or revocation of a private security license or certification under the Act or these administrative rules

(B) If the Department determines that a private security provider may have engaged in discretionary disqualifying misconduct, the case may be presented to the Board, through the Policy Committee. The Department will seek input from the affected private security provider by allowing the individual to provide, in writing, information for the Policy Committee and Board's review.

(d) Policy Committee and Board Review: In making a decision to authorize initiation of proceedings under subsection (e) of this rule based on discretionary disqualifying misconduct, the Policy Committee and Board will consider mitigating and aggravating circumstances.

(e) Initiation of Proceedings: Upon determination that a sufficient factual basis exists to support the request for denial, suspension, or revocation of a private security license or certification under the Act or these administrative rules, the Department will prepare and serve a contested case notice on the private security provider.

(A) All contested case notices will be prepared in accordance with the applicable provisions of the Attorney General's Model Rules of Procedure adopted under OAR 259-005-0015.

(B) In discretionary cases heard by a policy committee, the contested case notice will be served on the private security provider prior to Board review. If the Board disapproves the Policy Committee's recommendation, the Department will withdraw the contested case notice.

(C) Applicants who choose to withdraw their application forfeit their application fees.

(f) Response Time:

(A) A party who has been served with an Emergency Suspension Order has 90 days from the date of mailing or personal service of the Order in which to file a written request for hearing with the Department.

(B) A party who has been served with a Contested Case Notice of Intent to Deny Certification or Licensure has 60 days from the date of mailing or personal service of the notice in which to file a written request for hearing or a written request withdrawing their application from consideration with the Department.

(C) A party who has been served with a Contested Case Notice of Intent to Revoke Certification or Licensure has 20 days from the date of the mailing or personal service of the notice in which to file a written request for hearing with the Department.

(g) Default Order: If a timely request for a hearing is not received, the Contested Case Notice will become a final order denying or revoking certification pursuant to OAR 137-003-0672.

(h) Final Order:

(A) A final order will be issued pursuant to the applicable provisions of the Attorney General's Model Rules of Procedure adopted under OAR 259-005-0015 if a private security provider fails to file exceptions and arguments within 20 days of issuance of the proposed order.

(B) Department-proposed amendments to the proposed order in a case that was originally heard by a policy committee must be considered and approved by the policy committee that originally reviewed the case before a final order is issued.

(i) Stipulated Order Revoking Certification or Licensure: The Department may enter a stipulated order revoking certification or licensure of a private security provider upon the person's voluntary agreement to terminate an administrative proceeding to revoke a certification or license, or to surrender a certification or license, under the terms and conditions provided in the stipulated order.

Appeals, Ineligibility Period, and Reconsideration

(7) Appeal Procedure. Private security applicants and providers aggrieved by the findings and Order of the Department may file an appeal with the Court of Appeals from the Final Order of the Department, as provided in ORS 183.480.

(8) Notwithstanding section (9) of this rule, any private security applicant or provider whose certification or licensure is denied or revoked will be ineligible to hold any private security certification or licensure for a period of ten years from the date of the final order issued by the Department.

(9) Reconsideration Process. Any individual whose certification or license has been denied or revoked for discretionary grounds may apply for reconsideration of the denial or revocation after a minimum four-year ineligibility period from the date of the final order.

(a) All applicants for reconsideration are required to submit a new application packet along with a Form PS-30 Application for Reconsideration. The applicant may provide any mitigating information for the consideration of DPSST, Policy Committee, and Board.

(b) In reconsidering the application of an applicant whose certification or licensure was previously denied or revoked for discretionary grounds, DPSST, the Policy Committee and the Board may consider mitigating and aggravating circumstances.

(c) The Board's decision to deny an application for reconsideration will be subject to the contested case procedure described under subsection (6) of this rule.

(d) If an application for reconsideration is denied, the original ineligibility date remains in effect as described in subsection (8) of this rule.

Stat. Auth.: ORS 181.878, 181.882 & 181.885
Stats. Implemented: ORS 181.878 & 181.885
Hist.: PS 9-1997, f. & cert. ef. 8-20-97; PS 10-1997(Temp), f. & cert. ef. 11-5-97; BPSST 1-1998, f. & cert. ef. 5-6-98; BPSST 2-1998(Temp), f. & cert. ef. 5-6-98 thru 6-30-98; BPSST 3-1998, f. & cert. ef. 6-30-98; BPSST 3-1999(Temp), f. & cert. ef. 3-9-99 thru 9-5-99; BPSST 4-1999, f. 4-29-99, cert. ef. 9-5-99; BPSST 3-2000, f. & cert. ef. 8-10-00; BPSST 8-2001(Temp), f. & cert. ef. 8-22-01 thru 2-18-02; BPSST 18-2001(Temp), f. & cert. ef. 11-28-01 thru 2-18-02; BPSST 4-2002(Temp), f. & cert. ef. 2-25-02 thru 7-1-02; BPSST 13-2002, f. & cert. ef. 4-30-02 ; DPSST 4-2003, f. & cert. ef. 1-22-03; DPSST 10-2003(Temp), f. & cert. ef. 6-16-03 thru 12-1-03; DPSST 12-2003, f. & cert. ef. 7-24-03; DPSST 6-2004, f. & cert. ef. 4-23-04; DPSST 5-2005(Temp), f. & cert. ef. 8-3-05 thru 1-1-06; DPSST 10-2005, f. & cert. ef. 10-14-05; DPSST 6-2006, f. & cert. ef. 5-15-06; DPSST 25-2012, f. 10-26-12, cert. ef. 11-1-12; DPSST 12-2013, f. & cert. ef. 6-24-13

259-060-0450
Compliance

(1) The Department may cause administrative proceedings or court action to be initiated to enforce compliance with the Act and these rules.

(2) Violations. The Department may find violation and recommend assessment of civil penalties upon finding that a private security provider, individual, business or entity has previously engaged in or is currently engaging in any of the following acts:

(a) Providing private security services without valid certification or licensure or Temporary Work Permit;

(b) Failure to submit properly completed forms or documentation in a time frame as designated by the Department;

(c) The falsification of any documents submitted to the Department;

(d) Failure to cease providing private security services upon issuance of a cease and desist order, expiration of certification or licensure, notice of termination, suspension, denial or revocation;

(e) Failure to complete required training as prescribed in OAR 259-060-0060;

(f) Failure to report criminal charges as required in ORS 181.885;

(g) Providing training without a valid certification;

(h) Failure of a private security instructor to instruct the full Department-approved curriculum;

(i) Failure to terminate employment as a private security provider of an individual whose application has been terminated, or whose certification or licensure has been suspended, denied or revoked, upon notice from the Department to do so;

(j) Employing private security providers who have not completed the training and application process required under the Act and these rules;

(k) Failure to employ a licensed executive manager;

(l) Failure to provide technological communication or visibility of a certified security professional to crowd management staff;

(m) Failure to provide documentation of one certified security professional to ten crowd management staff;

(n) Expecting crowd management staff to perform security services duties other than the duties incidental to crowd management; or

(o) Any other violation of requirements of the Act or these rules.

(3) The Department may issue a Demand to Examine Books and Records (DEBR) to obtain any record or document related to compliance.

(a) The Department may cause inspection or audits of the records of any private security provider, business or entity. Records inspected may include any document relating to the requirements of the Act and these rules.

(b) Failure to cooperate or respond to any investigative inquiries or DEBR may result in issuance of a civil penalty as described in this rule and the revocation or denial of certification or licensure as described in OAR 259-060-0300.

(4) The Department may issue a Cease and Desist Order when an individual, business or entity is not in compliance with these rules. The order requires the individual, business or entity to cease and desist providing private security services in the state of Oregon and will remain in effect until the individual, business or entity gains compliance.

(5) Complaints and Allegations of Violations.

(a) All complaints or allegations of violations must be submitted on a Department-approved complaint form before an investigation can be initiated, unless the Department grants an exception. The Department may consider additional credible sources of information to determine non-compliance.

(b) A preliminary administrative review of the complaint or allegation will be conducted by the Department to ensure there is sufficient information to proceed. Staff may conduct a fact-finding preliminary investigation.

(A) If sufficient information is determined to support the compliant or allegation, the Department may open and conduct an investigation and gather relevant information.

(B) Private security providers, applicants, or other involved parties will respond to any questions or requests with 20 days after a request is mailed by the Department, unless an extension is requested and approved by the Department.

(6) Procedures for Proposing a Civil Penalty.

(a) The Department may issue an Allegation of Non-Compliance when there is a reason to believe a violation has occurred. The purpose of this document is to provide education and allow an opportunity to gain compliance within 30 days without penalty.

(b) The Department will issue a Notice of Violation upon discovery of violation as described in this rule. The Notice will include a statement of found violations and proposed sanctions. An individual, business or entity may be given the opportunity to remedy the violation and pay a penalty within 10 days of the mailing of the notice.

(c) The Department, through the Policy Committee and Board, will issue a Notice of Intent to Propose a Civil Penalty upon the failure to remedy a violation or request an extension within 10 days of the mailing of the Notice of Violation.

(A) The Department may extend the time to remedy a violation upon a showing of good cause.

(B) An individual, business or entity will be given the opportunity to provide mitigation to the Department.

(7) Hearing Request.

(a) If the Department issues a Notice of Intent to Propose Civil Penalty, an individual, business or entity is entitled to a contested case hearing in accordance with the applicable provisions of the Attorney General's Model Rules of Procedure adopted under OAR 259-005-0015.

(b) The Department must receive a request for hearing in writing within 20 days of the date the Notice of Intent to Propose Civil Penalty was served on the individual, business or entity.

(8) Default Order. If a timely request for a hearing is not received, the Notice of Intent to Impose a Civil Penalty will become a Final Order Imposing Civil Penalty.

(9) Resolution by Stipulation. The Department is authorized to seek resolution by stipulation, subject to acceptance and approval by the Board or Director, if:

(a) The matter is resolved before entry of a final order assessing penalty;

(b) The respondent satisfies all terms set forth by the Department within the time allowed; and

(c) Any stipulated penalty amount is received by the Department.

(10) Civil Penalty Amounts.

(a) Unarmed private security providers and alarm monitors will be charged a penalty of not less than $250 for the first violation and a maximum of $1,500 for each flagrant violation.

(b) Armed private security providers will be charged a penalty of not less than $500 for the first violation and a maximum of $1,500 for each flagrant violation.

(c) Private security instructors will be charged a penalty of not less than $750 for the first violation and a maximum of $1,500 for each flagrant violation.

(d) Private security managers, contract executive managers and business or entity owners that employ private security staff will be charged a penalty of not less than $1,000 for the first violation and a maximum of $1,500 for each flagrant violation.

(e) For the purposes of imposing civil penalties, each 30 day period in violation of the same statute or rule may be considered a separate violation by the Department.

(11) The Department may reduce or waive civil penalties from the amounts set in this rule in situations where further mitigation is warranted or the matter is resolved by stipulation at any time prior to the entry of a final order.

(12) Staff will recommend the full civil penalty amount for individuals, businesses or entities that fail to satisfy the terms as stipulated. The recommendation will be reviewed by the Policy Committee and Board.

Stat. Auth.: ORS 181.878
Stats. Implemented: ORS 181.878
Hist.: PS 9-1997, f. & cert. ef. 8-20-97; PS 10-1997(Temp), f. & cert. ef. 11-5-97; BPSST 1-1998, f. & cert. ef. 5-6-98; BPSST 2-1998(Temp), f. & cert. ef. 5-6-98 thru 6-30-98; BPSST 3-1998, f. & cert. ef. 6-30-98; BPSST 3-1999(Temp), f. & cert. ef. 3-9-99 thru 9-5-99; BPSST 4-1999, f. 4-29-99, cert. ef. 9-5-99; BPSST 3-2000, f. & cert. ef. 8-10-00; BPSST 8-2001(Temp), f. & cert. ef. 8-22-01 thru 2-18-02; BPSST 18-2001(Temp), f. & cert. ef. 11-28-01 thru 2-18-02; BPSST 4-2002(Temp), f. & cert. ef. 2-25-02 thru 7-1-02; BPSST 13-2002, f. & cert. ef. 4-30-02; DPSST 4-2003, f. & cert. ef. 1-22-03; DPSST 6-2006, f. & cert. ef. 5-15-06; DPSST 11-2007, f. & cert. ef. 10-15-07; DPSST 6-2008, f. & cert. ef. 4-15-08; DPSST 25-2012, f. 10-26-12, cert. ef. 11-1-12; DPSST 12-2013, f. & cert. ef. 6-24-13

259-060-0500
License Fees

(1) Payments to the Department are non-refundable and non-transferable and must be paid by business check, money order, cashier's check or credit card. No personal checks or cash will be accepted.

(2) The Department will charge the following fees:

(a) The fee of $65 for the issuance of each two-year certification as a private security professional.

(b) Appropriate fees must be submitted with each application for a fingerprint criminal history check. These fees are to recover the costs of administering the fingerprint check through the Oregon State Police and Federal Bureau of Investigation. An additional fee will be charged for the third submittal of fingerprint cards when rejected for filing by FBI. Current fee schedules for processing fingerprints may be obtained from the Department.

(c) The fee of $75 for the issuance of a two-year license as a supervisory manager.

(d) The fee of $250 for the issuance of a two-year license as an executive manager.

(e) The fee of $90 for the issuance of a two-year certification as a private security instructor.

(f) The fee of $20 for the issuance of each upgrade, duplicate or replacement card issued.

(g) The late submission penalty fee of $25 will be added to the fees for recertification if the provider fails to complete certification by the expiration date of the license or certificate.

(h) In the event a non-sufficient check is received for payment, an additional $25 administrative fee will be assessed.

Stat. Auth.: ORS 181.878

Stats. Implemented: ORS 181.878

Hist.: PS 1-1997(Temp), f. 2-21-97, cert. ef. 2-24-97; PS 9-1997, f. & cert. ef. 8-20-97; PS 10-1997(Temp), f. & cert. ef. 11-5-97; BPSST 1-1998, f. & cert. ef. 5-6-98; BPSST 2-1998(Temp), f. & cert. ef. 5-6-98 thru 6-30-98; BPSST 3-1998, f. & cert. ef. 6-30-98; BPSST 3-1999(Temp), f. & cert. ef. 3-9-99 thru 9-5-99; BPSST 4-1999, f. 4-29-99, cert. ef. 9-5-99; BPSST 3-2000, f. & cert. ef. 8-10-00; BPSST 8-2001(Temp), f. & cert. ef. 8-22-01 thru 2-18-02; BPSST 18-2001(Temp), f. & cert. ef. 11-28-01 thru 2-18-02; BPSST 4-2002(Temp), f. & cert. ef. 2-25-02 thru 7-1-02; BPSST 13-2002, f. & cert. ef. 4-30-02; DPSST 12-2003, f. & cert. ef. 7-24-03; DPSST 3-2005(Temp), f. 4-25-05, cert. ef. 5-1-05 thru 10-28-05; DPSST 11-2005, f. & cert. ef. 10-14-05; DPSST 6-2006, f. & cert. ef. 5-15-06; DPSST 6-2008, f. & cert. ef. 4-15-08; DPSST 6-02010(T), f. 6-14-10, cert. ef. 7-1-10 thru 12-27-10; DPSST 12-2010, f. & cert. ef. 11-12-10; DPSST 6-2011(Temp), f. 6-14-11, cert. ef. 7-1-1 thru 12-1-11; DPSST 12-2011, f. & cert. ef. 8-1-11; DPSST 25-2012, f. 10-26-12, cert. ef. 11-1-12; DPSST 12-2013, f. & cert. ef. 6-24-13

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Rule Caption: Establish Law Enforcement Medal of Ultimate Sacrifice (2011 SB 976).
Adm. Order No.: DPSST 13-2013
Filed with Sec. of State: 6-24-2013
Certified to be Effective: 6-24-13
Notice Publication Date: 6-1-2013
Rules Amended: 259-008-0100
Subject: Establishes qualification and processes for awarding the Law Enforcement Medal of Ultimate Sacrifice which was enacted when SB 976 passed during the 2011 Legislative Session.
Rules Coordinator: Linsay Hale—(503) 378-2431

259-008-0100
Miscellaneous Activities of the Board or Department

(1) The Board or Department may make or encourage studies of any aspect of corrections, parole and probation, telecommunications, emergency medical dispatch, fire, or police administration, including the stimulation of research by public and private agencies which shall be designed to improve the Criminal Justice System.

(2) The Board or Department may cooperate and consult with counties, municipalities, agencies of this State, other governmental agencies, and with universities, colleges, community colleges, and other institutions concerning the development of criminal justice training schools and programs or courses of instruction.

(3) The Board or Department may cooperate and consult with official bodies or individuals charged by law with the responsibility for corrections, parole and probation, telecommunications, emergency medical dispatch, fire or police selection and training standards in other states.

(4) The Board or Department may periodically publish or recommend that other governmental agencies publish curricula, manuals, lesson plans, brochures, newsletters, and other materials to aid departments in achieving the objectives of the Act.

(5) The Department may direct, operate, or sponsor training schools and set reasonable rules and regulations for the operation and use by trainees.

(6) The Department may, on request, issue Retirement Cards to those Department-certified public safety professionals who have honorably served the citizens of Oregon and who have honorably retired from their agency.

(a) For the purposes of this rule, "honorably retired" means reaching the State of Oregon's recognized retirement age and retiring in good standing from a certified position as a public safety professional with a minimum of five (5) years of full-time public safety experience in Oregon.

(b) A public safety professional who has sustained a permanent disability that prevents a return to their certifiable position may qualify for a Retirement Card if the public safety professional has served a minimum of five (5) years as a full-time public safety professional in Oregon.

(c) The request for a Retirement Card must be made by the agency with which the public safety professional was last employed prior to retirement. The request must be made using a Form F-30 Retirement Card Request Form.

(d) The Department will issue only one Retirement Card per qualifying public safety professional.

(e) If a Retirement Card is lost or damaged, the Department may issue a replacement Card if requested by the applicable public safety professional. Additional verification of original eligibility may be required.

(7) In accordance with the Oregon Revised Statutes the Board, in consultation with the Department, designates the following classifications of public safety personnel killed in the line of duty who may be honored at the Law Enforcement Memorial Wall.

(a) Eligibility:

(A) For the purpose of placing names, law enforcement officer includes, as defined in ORS 181.610, police officer, reserve officer, corrections officer, and parole and probation officer. Also included are federal law enforcement officers assigned to or performing law enforcement duties in Oregon.

(b) Criteria for placement on the Law Enforcement Memorial Wall:

(A) Officers who suffered an "in-the-line-of-duty" death.

(i) "In the line of duty death" means a fatal injury which is the direct or proximate result of any enforcement action or emergency response resulting in death or death directly resulting from law enforcement training for enforcement action or emergency response that the law enforcement officer is authorized or obligated to perform by law, rule, regulation, or condition of employment or service while on or off duty.

(ii) A fatal injury may include a medical condition which arises out of law enforcement actions or training for enforcement action or emergency response causing an officer's death immediately or within 24 hours or causing her/his death during a continuous period of hospitalization resulting from a law enforcement action.

(iii) Not included under this definition are deaths attributed to natural causes (except when a medical condition arises out of law enforcement action or law enforcement training for enforcement action or emergency response causing an officer's death immediately or within 24 hours or causing his/her death during a continuous period of hospitalization immediately following the taking of law enforcement action). Deaths attributed to voluntary alcohol or controlled substance abuse, deaths caused by the intentional misconduct of the officer, deaths caused by the officer's intention to bring about his or her own death, and deaths attributed to an officer performing his/her duty in a grossly negligent manner at time of death are not included under this definition.

(iv) When there is doubt arising from circumstances of the officer's death or with respect to individual status as a law enforcement officer, the matter shall be resolved by a majority vote of the Board on Public Safety Standards and Training Executive Committee.

(c) Exclusions from the Law Enforcement Memorial Wall:

(A) Officers whose deaths are attributed to natural causes are not eligible for inclusion in the wall; or

(B) A death that is attributed to the officer's voluntary alcohol or substance abuse use; or

(C) Death caused by intentional misconduct of the officer; or

(D) Death caused by the officer's intention to bring about his or her own death; and

(E) Death attributed to an officer performing his or her duty in a grossly negligent manner at the time of death.

(d) When there is doubt arising from the circumstances of the officer's death or with respect to the individual status as a law enforcement officer, the matter shall be resolved by a majority vote of the Executive Committee.

(e) The costs of maintenance and relocation of the Law Enforcement Memorial Wall and the costs of an annual memorial service honoring persons killed in the line of duty shall be paid out of the Police Memorial Trust Fund.

(8) It is the responsibility of the Governor's Commission on the Law Enforcement Medal of Honor to establish qualification criteria for nomination for the Law Enforcement Medal of Honor and the Law Enforcement Medal of Ultimate Sacrifice.

(a) Eligibility. For the purposes of nomination, law enforcement officer includes, but is not limited to, a police officer, reserve officer, corrections officer, or parole and probation officer. Also included are any state, county, municipal, federal or tribal individual who is:

(A) Commissioned; and

(B) Responsible for enforcing criminal laws in the state of Oregon.

(b) Officers nominated for the Law Enforcement Medal of Honor must have distinguished themselves by exceptionally honorable and meritorious conduct while in the performance of duty.

(A) "Exceptionally honorable and meritorious conduct" means an officer has distinguished themselves conspicuously by gallantry and fortitude at the risk of their life "above and beyond" the call of duty while performing or fulfilling their responsibilities as a law enforcement officer. It involves risk of life and is an act of bravery, self-sacrifice so conspicuous as to clearly distinguish the individual above their comrades.

(B) "While in the performance of duty" requires acting in an official capacity and performing a law enforcement function.

(C) The exceptionally honorable and meritorious conduct must have occurred on or after January 1, 2006.

(c) Officers nominated for the Law Enforcement Medal of Ultimate Sacrifice must have died while performing duties as a law enforcement officer or have been killed because of employment as a law enforcement officer. The death must have occurred on or after January 1, 2011.

(d) Process for Nominations.

(A) All nominations must be submitted on an official nomination form to the Department of Public Safety Standards and Training.

(B) All nominations must be postmarked no later than one year after the date an officer has performed exceptionally honorable and meritorious conduct or the death of an officer.

(C) All nominations must be approved by the Department head or designee of the nominee.

(D) Commission members are prohibited from voting on any nomination submitted from their employing agency.

(E) Notwithstanding subsection (D), Commission members must unanimously approve nominations for the Law Enforcement Medal of Honor.

(F) Any supporting documentation including, but not limited to, police reports, media reports, pictures, testimonials or affidavits, must accompany the nomination form. If necessary, the Commission may request additional information. The request will be in writing and addressed to the individual identified as the contributor on an official nomination form.

(e) Award of the Law Enforcement Medal of Honor and Law Enforcement Medal of Ultimate Sacrifice.

(A) All awards will be presented by the Governor or the Governor's designee at an appropriate time determined by the Commission and approved by the Governor.

(B) An individual or family member receiving the Law Enforcement Medal of Honor or Law Enforcement Medal of Ultimate Sacrifice will retain the option for a public or private ceremony.

(C) The Commission will determine the protocol for all award ceremonies.

Stat. Auth.: ORS 176.260 & 181.640
Stats. Implemented: ORS 176.260 & 181.640
Hist.: PS 12, f. & ef. 12-19-77; PS 1-1985, f. & ef. 4-24-85; Renumbered from 259-010-0080, PS 1-1990, f. & cert. ef. 2-7-90; PS 2-1995, f. & cert. ef. 9-27-95; PS 10-1997(Temp), f. & cert. ef. 11-5-97; BPSST 1-1998, f. & cert. ef. 5-6-98; BPSST 2-1998(Temp), f. & cert. ef. 5-6-98 thru 6-30-98; BPSST 3-1998, f. & cert. ef. 6-30-98; BPSST 16-2001(Temp), f. & cert. ef. 10-26-01 thru 4-5-02; Administrative correction 5-7-02; BPSST 17-2002, f. & cert. ef. 7-5-02; DPSST 12-2007, f. & cert. ef. 10-15-07; DPSST 10-2012, f.& cert. ef. 4-9-12; DPSST 13-2013, f. & cert. ef. 6-24-13

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Rule Caption: Clarify application process for Private Investigator licensure.
Adm. Order No.: DPSST 14-2013
Filed with Sec. of State: 6-24-2013
Certified to be Effective: 6-24-13
Notice Publication Date: 6-1-2013
Rules Amended: 259-061-0020
Subject: Clarifies the application process for Private Investigator licensure by correction form references, rule citations, omissions and typographical errors.
Rules Coordinator: Linsay Hale—(503) 378-2431

259-061-0020
Application for Private Investigator Licensure

(1) All applicants for licensure must meet all minimum standards for licensure as described in OAR 259-061-0040.

(2) Applications for new licensure as an investigator must include:

(a) A completed Form PI-1 (Application for Licensure);

(b) A completed fingerprint packet. A fingerprint packet must include a pre-printed FBI fingerprint card and a Form PI-4 (Affidavit of Person Rolling Fingerprints) completed by the person rolling or scanning the fingerprints. The card and form must be enclosed in a tamper-proof bag and sealed by the person who rolled or scanned the fingerprints before the packet is returned to the applicant. The Department will supply pre-printed FBI fingerprint cards and tamper-proof bags;

(A) The Department will only accept fingerprint cards correctly rolled and completed by private or public safety personnel trained to roll or scan fingerprints, or a person who is employed and trained by a private business that provides fingerprinting services.

(B) If a fingerprint card is rejected twice by the Federal Bureau of Investigation (FBI), the applicant will be charged a fee for a third submittal of a fingerprint card.

(c) Proof of a corporate surety bond, an irrevocable letter of credit issued by an Oregon commercial bank as defined in ORS 706.008, or errors and omission insurance in the amount of at least $5,000;

(A) Bonds and letters of credit must have the applicant's name listed as the principal.

(B) Proof of surety bonds must be submitted on a Department-approved form and will not be valid for the purposes of licensure unless filed with the Department within 60 days of the signature on the bond.

(C) An irrevocable letter of credit submitted to the Department is subject to approval by the Department prior to the issuance of a license.

(D) Errors and Omission insurance must have the applicant's name listed on the Certificate of Liability or include a letter from the employing agency or insurance company confirming the applicant is covered as an employee.

(d) Two identical, passport-quality photographs for identification;

(A) Photographs must be in color with a solid-colored background and must be a cropped head shot. The applicant's face must be clearly visible and free from shadows or other obstacles. Photocopies will not be accepted.

(B) The applicant's head in the photograph must be no be more than 1" wide and 1.25" high.

(C) Photographs must have been taken not more than six months prior to filing of the application for licensure.

(D) Photographs may be submitted to the Department digitally in the format prescribed on the Form PI-1.

(e) A completed Form PI-27 (Investigator Professional Code of Ethics) affirming moral fitness and professional standards; and

(f) Three professional letters of reference, none of which may be from a person who is related to the applicant by blood or marriage.

(g) Proof of a passing score on the Private Investigator Proficiency Exam administered by the Department.

(h) Non-refundable application fees as prescribed by OAR 259-061-0010.

(3) Applications for renewing licensure as an investigator must include:

(a) A Form PI-21 (Investigator Renewal Application) completed in its entirety;

(b) A completed Form PI-6 (Continuing Education Summary.)

(c) Two identical, passport-quality photographs for identification in accordance with subsection (2)(d) of this rule.

(d) A completed Form PI-27 (Investigator Professional Code of Ethics) affirming moral fitness and professional standards; and

(e) Proof of a corporate surety bond, an irrevocable letter of credit issued by an Oregon commercial bank as defined in ORS 706.008, or errors and omission insurance in the amount of at least $5,000 in accordance with this rule; and

(f) Non-refundable renewal application fees as prescribed by OAR 259-061-0010.

(4) Timelines.

(a) A completed application packet must be mailed to the Department and postmarked prior to the applicant performing any investigatory work.

(b) Renewal application documents must be received by the Department within 90 days prior to the expiration date of the licensure to allow for processing of the forms and criminal history check.

(c) A late submission fee will be assessed as prescribed by OAR 259-061-0010 if reapplying after the license expiration date of the licensure.

(d) Applicants renewing their licensure more than 30 days after the expiration date of the original license must submit the following:

(A) A new application packet in accordance with subsection (2) of this rule; and

(B) A Form PI-6.

(5) Applicants for licensure who were previously licensed in Oregon must provide proof of completion of continuing education requirements or a written explanation detailing why continuing education requirements were not met and a written plan detailing how the continuing education will be made up, including a time line. The Department, at its discretion, may accept the plan in place of completed continuing education.

(6) Submission of any false information in connection with an application, supporting documentation or attachments for a license or registration may be grounds for discipline, criminal penalty, or civil penalty.

(7) The Department may administratively terminate the application process, upon written notification to the applicant, for any of the following reasons:

(a) The Department has reason to believe that the applicant has committed an act that constitutes ground for denial of a license as described in OAR 259-061-0040. The termination of an application due to criminal conviction disqualification is subject to the contested case procedures set forth in OAR 259-061-0040;

(b) The application or any required documentation is incomplete or the Department is unable to satisfactorily verify application information due to non-response or non-compliance of the application;

(c) The fingerprint cards of an applicant have been rejected and returned by the Oregon State Police or Federal Bureau of Investigation;

(8) The Department may administratively terminate the application process after exhausting the following efforts:

(a) A letter will be mailed by the Department to the applicant at the last known mailing address identifying the deficiencies in the application process. The applicant will have 21 calendar days from the date of the mailing to notify the Department that the deficiencies are corrected. The Department may extend the time for compliance upon good cause shown by the applicant.

(b) If the Department is unable to determine a current address for the application, or if the applicant does not respond and correct the deficiencies within 21 calendar days, or such additional time authorized by the Department, the Department will list the applicant's status as "administratively terminated." The Department will notify the applicant at the last known address that the Department has administratively terminated the application process.

(c) Once the application process has been administratively terminated, the applicant must reapply by submitting a new completed application packet with all deficiencies corrected, including new fees and proof of valid training.

(9) Any exception to the application process found in this rule must be approved by the Department.

Stat. Auth.: ORS 703.415, 703.425, 703.430, 703.435, 703.445, 703.450, 703.460, 703.465 & 703.480

Stats. Implemented: ORS 703.401 - 703.995

Hist.: DPSST 7-2006, f. & cert. ef. 5-15-06; DPSST 2-2013, f. & cert. ef. 1-2-13; DPSST 14-2013, f. & cert. ef. 6-24-13

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Rule Caption: Allows the Department to prescribe additional training requirements in situations of limited periods of employment.
Adm. Order No.: DPSST 15-2013
Filed with Sec. of State: 6-25-2013
Certified to be Effective: 6-25-13
Notice Publication Date: 6-1-2013
Rules Amended: 259-008-0025
Subject: Adds an exception to rule to allow the Department to prescribe additional training in situations where limited or sporadic periods of employment could potentially create a liability for the employing agency and the Department.
Rules Coordinator: Linsay Hale—(503) 378-2431

259-008-0025
Minimum Standards for Training

(1) Basic Course:

(a) Except as provided in OAR 259-008-0035, all law enforcement officers, telecommunicators, and emergency medical dispatchers must satisfactorily complete the prescribed Basic Course, including the field training portion. The Basic Course and field training portion must be completed within twelve months from the date of employment by corrections officers and within 18 months by police officers, parole and probation officers, telecommunicators, and emergency medical dispatchers.

(b) The field training program shall be conducted under the supervision of the employing department. When the field training manual is properly completed, the sign-off pages of the field training manual must be forwarded to the Department. Upon the approval of the Department, the employee shall receive credit toward basic certification.

(c) Effective July 1, 2007, all police officers must satisfactorily complete the Department's physical fitness standard. The Department's physical standard is:

(A) Successful completion of the OR-PAT at 5:30 (five minutes and thirty seconds) when tested upon entry at the Basic Police Course; or

(B) Successful completion of the OR-PAT at 5:30 (five minutes and thirty seconds) when tested prior to graduation from the Basic Police Course.

(d) Law enforcement officers who have previously completed the Basic Course, but have not been employed as a law enforcement officer as defined in ORS 181.610 and OAR 259-008-0005 during the last five (5) years or more, must satisfactorily complete the full required Basic Course to qualify for certification. This requirement may be waived by the Department upon a finding that the applicant has current knowledge and skills to perform as an officer.

(e) Telecommunicators and emergency medical dispatchers who have previously completed the Basic Course, but have not been employed as a telecommunicator or EMD, as described in ORS 181.610 and OAR 259-008-0005 for two and one-half (2-1/2) years or more, must satisfactorily complete the full required Basic Course to qualify for certification. This requirement may be waived by the Department upon finding that a Telecommunicator has current knowledge and skills to perform as a Telecommunicator. There is no waiver available for an emergency medical dispatcher.

(f) Previously employed telecommunicators may challenge the Basic Telecommunications Course based on the following criteria:

(A) The department head of the applicant's employing agency shall submit the "challenge request" within the time limits set forth in the Oregon Revised Statutes and Oregon Administrative Rules.

(B) The applicant must provide proof of successful completion of prior equivalent training.

(C) The applicant must provide documentation of the course content with hour and subject breakdown.

(D) The applicant must obtain a minimum passing score on all written examinations for the course.

(E) The applicant must demonstrate performance at the minimum acceptable level for the course.

(F) Failure of written examination or demonstrated performance shall require attendance of the course challenged.

(G) The applicant will only be given one opportunity to challenge a course.

(g) Previously employed police officers, corrections officers and parole and probation officers who are required to attend the Basic Course may not challenge the Basic Course.

(h) All law enforcement officers who have previously completed the Basic Course, but have not been employed as a law enforcement officer as described in ORS 181.610 and OAR 259-008-0005 over two and one-half (2-1/2) years but less than five (5) years must complete a Career Officer Development Course if returning to the same discipline. This requirement may be waived after a staff determination that the applicant has demonstrated the knowledge and skills required for satisfactory completion of a Career Officer Development Course.

(i) Corrections and police officers who have not completed the Basic Course must begin training within 90 days of their initial date of employment.

(A) A police officer must begin training at an academy operated by the Department.

(B) A corrections officer who is employed by Oregon Department of Corrections (DOC) during the period July 1, 2009 through January 1, 2014 must begin DOC Basic Corrections Course (DOC BCC) training provided by DOC as described in section (6) of this rule.

(C) A corrections officer who is not employed by DOC must begin training at an academy operated by the Department.

(D) A 30-day extension of this time period shall be granted by the Board or its designee upon receipt of a written statement of the reasons for the delay from the officer's employer. Any delays caused by the inability of the Department to provide basic training for any reason, shall not be counted as part of the periods set forth above (refer to ORS 181.665 and 181.652).

(j) Law enforcement officers who have previously completed a basic training course out of state while employed by a law enforcement unit, or public or private safety agency, may, upon proper documentation of such training and with approval of the Department, satisfy the requirements of this section by successfully completing a prescribed Career Officer Development Course or other appropriate course of instruction.

(k) The basic course for police officers must include:

(A) Training on the law, theory, policies and practices related to vehicle pursuit driving;

(B) Vehicle pursuit training exercises, subject to the availability of funding; and

(C) A minimum of 24 hours of training in the recognition of mental illnesses utilizing a crisis intervention training model. A minimum of one hour of this training must be on the appropriate use of the medical health database maintained by the Department of State Police within the Law Enforcement Data System.

(2) Career Officer Development Course:

(a) All law enforcement officers who have not been employed as such for between two and one half (2-1/2) years and five (5) years, must satisfactorily complete a Career Officer Development Course approved by the Department.

(b) A law enforcement officer assigned to a Career Officer Development Course must also complete the Board's field training program under the supervision of the employing department and submit to the Department a properly completed Field Training Manual. The Department may waive the Field Training Manual requirement upon demonstration by the employing agency that it is not necessary [refer to OAR 259-008-0025(1)(b)].

(A) A law enforcement officer who fails to achieve a minimum passing test score after completing a Career Officer Development Course will be given one opportunity to remediate through self-study and re-test within 60 days of the initial date of failure.

(B) A law enforcement officer who fails to achieve a minimum passing test score after re-testing will have been determined to have failed academically and will be required to attend the next available Basic Course.

(C) A law enforcement officer who is scheduled to complete a distance learning COD Course must achieve a minimum passing test score within the timeframe set by the Department. Failure to successfully complete a distance COD Course within the timeframe set by the Department will require an officer to attend the next available COD Course.

(c) The Department may also require successful completion of additional specified courses or remedial training.

(3) Supervision Course. All law enforcement officers, telecommunicators, and emergency medical dispatchers promoted, appointed, or transferred to a first-level supervisory position must satisfactorily complete Supervision training that complies with the requirements outlined in DPSST Form F-21. The required training must be completed within 12 months after initial promotion, appointment, or transfer to such position. This section applies whether the individual is promoted or transferred to a supervisory position within a department, or is appointed from an outside department, without having completed the required Supervision training within the preceding five (5) years.

(4) Middle Management Course. All law enforcement officers, telecommunicators, and emergency medical dispatchers promoted, appointed, or transferred to a middle management position must satisfactorily complete Middle Management training that complies with the requirements outlined in DPSST Form F-22. The required training must be completed within 12 months after initial promotion, appointment, or transfer to such position. This section applies whether the individual is promoted or transferred to a middle management position within a department, or is appointed to the position from an outside department without having completed the required Middle Management training within the preceding five (5) years.

(5) Specialized Courses.

(a) Specialized courses are optional and may be presented at the Academy or regionally. The curriculum is generally selected because of relevancy to current trends and needs in police, corrections, parole and probation, telecommunications, and emergency medical dispatch fields, at the local or statewide level.

(b) Specialized courses may be developed and presented by individual departments of the criminal justice system, local training districts, a college, the Department, or other interested persons. Department staff may be available to provide assistance when resources are not available in the local region.

(c) Police officers, including certified reserve officers, must be trained on how to investigate and report cases of missing children and adults.

(A) The above mandated training is subject to the availability of funds.

(B) Federal training programs must be offered to police officers, including certified reserve officers, when they are made available at no cost to the state.

(6) The DOC Basic Corrections Course.

Course Requirements

(a) Except as provided in OAR 259-008-0035, all corrections officers hired by the Oregon Department of Corrections (DOC) on or after July 1, 2009, but prior to January 1, 2014, must satisfactorily complete the DOC Basic Corrections Course (DOC BCC), including the field training portion. All corrections officers must complete the DOC BCC and field training portion must be completed within twelve months from the date of employment.

(b) Prior to attending a DOC BCC, a corrections officer hired by DOC on or after July 1, 2009, but prior to January 1, 2014, must:

(A) Meet the minimum standards for employment as a law enforcement officer contained in OAR 259-008-0010;

(B) Meet the background investigation requirements for a law enforcement officer contained in OAR 259-008-0015; and

(C) Meet the minimum standards for training contained in this section.

(c) The DOC BCC must conform to the content and standard approved by the Board. The DOC BCC must include, but is not limited to:

(A) Minimum training standards for the basic certification of corrections officer employed by DOC. The minimum training developed by DOC must be adopted by the Board and must meet or exceed the minimum training standards for the basic certification of corrections officers employed by a law enforcement unit other than DOC.

(B) Minimum Course Hours. The minimum course hours are 240. DOC BCC Course hours refer to hours of training related to DPSST Instructional Goals and may include classroom, scenarios, skills sheets or other related training methodology

(i) The DOC BCC must include hours addressing all Instructional Goals within each of the following sections:

(I) Section A — 20 hours in Legal Considerations;

(II) Section B — 37 hours in Security Procedures;

(III) Section C — 43 hours in Inmate Supervision;

(IV) Section D — 16 hours in Inmate Health Care;

(V) Section E — 16 hours in Professional Skills;

(VI) Section F — 27 hours in Personal Fitness;

(VII) Section G — 41 hours in Defensive Tactics; and

(VIII) Section H — 26 hours in Skills — Firearms.

(ii) Administrative time is not included within the hours identified in subsection (i). Administrative time may be up to 6% of the overall course hours, or a maximum of 14 hours.

(iii) A minimum of 80% of the classes in the DOC BCC must include:

(I) Participatory learning activities which include, but are not limited to, scenario training, hands-on training and problem-based learning; and

(II) Sufficient hours to address the Instructional Goals in subsection (i).

(C) Attendance Standards. Attendance rosters must be kept and copies of these rosters must be submitted to the Department at the conclusion of a student's training, or when requested by the Department. To successfully complete the DOC BCC, a student may not miss more than 10% of the DOC BCC.

(D) Notwithstanding (C) above, successful completion of the DOC BCC requires 100% attendance during classes in which the following Instructional Goals are covered:

(i) B1.2 Instruction and practice applying safe and efficient tactics for inmate monitoring, inmate counts and facility perimeter checks;

(ii) B2.2 Instruction and practice conducting appropriate, safe and systematic searches of inmates and correctional facilities;

(iii) B5.2 Instruction and practice restraining individuals in an appropriate, safe and systematic manner;

(iv) B8 Reality based scenarios that enhance a new corrections professional's understanding and application of security procedures in a correctional facility;

(v) C3.2 Instruction and practice using interpersonal skills to effectively communicate with inmates and other persons in a correctional setting;

(vi) C10 Reality-based scenarios that enhance a new corrections professional's understanding and application of inmate supervision strategies within a correctional facility;

(vii) D3.2 Instruction and practice applying appropriate intervention strategies for dealing with inmates with major mental illnesses;

(viii) G1 Decision-making skills related to the use of reasonable force to effectively overcome and control resistive and/or hostile behavior;

(ix) G2 Instruction and practice using reasonable force tactics to effectively overcome and control resistive and/or hostile behavior;

(x) G3 Reality-based scenarios that enhance a new corrections professional's understanding and application of reasonable force decision-making and tactics within a correctional facility.;

(xi) H1 Basic gun-handling skills; and

(xii) H2 Basic understanding of the use, limitations and techniques of a service handgun, and proficiency in safety, proper gun-handling, marksmanship and firearms tactics.

(E) Conduct. An individual attending a DOC BCC is expected to uphold the minimum moral fitness standards for Oregon public safety officers during their training. DOC will document the date, type, and disposition of any student misconduct relating to the minimum standards for correctional officers. These include, but are not limited to, the following Zero Tolerance Offenses:

(i) Any unlawful act;

(ii) Dishonesty, lying or attempting to conceal violations;

(iii) Cheating;

(iv) Harassment; or

(v) Alcohol possession or use at the training venue.

(F) Course Curriculum.

(i) The DOC BCC will be based on the critical and essential job tasks identified in the most current Job Task Analysis for corrections officers provided to DOC by the Department.

(ii) The DOC BCC will incorporate the most current Instructional Goals provided to DOC by the Department.

(iii) The DOC BCC will incorporate curriculum updates provided to DOC by the Department, when those updates address the critical and essential job tasks or Instructional Goals referenced above.

Testing Requirements

(G) Academic Testing. Academic testing will consist of written test questions that are valid, create reasonable academic rigor, and require students to demonstrate knowledge and application of the essential tasks identified within the DOC BCC curriculum. DOC must administer examinations and maintain a file of examinations conducted.

(i) Academic Testing Passing Score. Except as provided below, to successfully complete the DOC BCC, students must achieve a minimum score of 75% on each academic test. If a student does not attain a 75% score, and DOC retains the student as an employee in a certifiable position, DOC must remediate the student. After remediation, a student will be allowed one opportunity to re-test and achieve a minimum score of 75%.

(ii) Students must attain a score of 100% on all academic test questions on Use of Force topics. If a student fails to attain a 100% score on Use of Force topics, and DOC retains the student as an employee in a certifiable position, DOC must remediate the student. Remediation must include the student completing the DPSST Use of Force Remediation form to demonstrate understanding of each topic missed.

(H) Skills Testing. Skills testing will consist of evaluations documented by use of Skills Sheets during which students must demonstrate competence and achieve a "pass" score in each skill tested.

(I) Test Security and Integrity.

(i) DOC must develop and strictly enforce measures to ensure the security of test questions and integrity of all testing processes.

(ii) DOC must randomize the order of test questions and must develop a sufficient bank of test questions to ensure that students who fail to achieve a passing score and are remediated are given a randomized test that includes some questions that are different than those in the test the student originally failed.

Instructor Requirements

(J) Instructor Qualifications.

(i) All instructors for the DOC BCC must meet or exceed the Instructor Certification standards for instructors at DPSST Basic courses and must be currently certified by the Department in the categories instructed.

(ii) DOC must verify that an instructor providing instruction within a category has the requisite subject matter knowledge, skills and abilities.

(K) The equivalency of the DOC BCC is subject to approval by the Board and verified by ongoing audits.

(L) DOC BCC documentation must include, but is not limited to:

(i) Training schedules, to include all training related to DOC BCC hours, such as classroom, skills sheets, online training and scenarios;

(ii) Classes with associated Instructional Goals and related hours;

(iii) Participatory learning activities within each class;

(iv) Testing Measures for each class; and

(v) Attendance rosters.

(M) DOC BCC Class Training Schedule documentation for each DOC BCC must include, but is not limited to:

(i) Notification of all anticipated DOC BCC training dates to include DOC BCC remediation training;

(ii) Times of DOC BCC training;

(iii) Locations of DOC BCC training; and

(iv) Instructors scheduled to provide training.

(N) Ongoing DOC BCC student documentation during each DOC BCC must include, but is not limited to:

(i) A list of students scheduled to attend training;

(ii) Student names, DPSST numbers, dates of employment and employing institutions;

(iii) Identification of any class or skill failure requiring remediation to including, but not limited to, the date and location of failure, date and location of remediation, the instructor who had oversight over remediation, and the result of remediation.

Certification Requirements

(O) Officer Certification. The applicant must meet the minimum standards for certification as a corrections officer contained in OAR 259-008-0060. DOC must submit the following documents at the time Basic certification is requested:

(i) F-7 (Application for Certification);

(ii) F-6 (Course Roster) for DOC BCC including the number of hours and the final cumulative score;

(iii) F-6 (Course Roster) for DOC Advanced Corrections Course with attached itemized list of classes attended;

(iv) Proof of current First Aid/CPR;

(v) F-11 (Criminal Justice Code of Ethics); and

(vi) FTO Manual Completion Report.

(P) Course Certification. Each DOC BCC class must be certified before officers who complete that BCC may be certified. The following Class Notebook requirements are needed prior to course certification:

(i) F-6 DPSST Class Roster, listing all students who began the course, passed or failed the course, and those who did not complete the course.

(ii) Curriculum for all components of the BCC, to include classroom, skills, online, and scenario training. The curriculum components must include lesson outlines, PowerPoint, handouts and other related documents to support each class.

(iii) Schedule of classes within the course, to include roster for each class, weekly schedule outlining the dates of training, the location of training, the phases of training, the number of hours for each class, the name of the class, the instructors who provided instruction.

(iv) Documentation of all training failures and remediation, to include class, date and location of training failure, the type of failure, the date, location and instructor who had oversight over the remediation of the failure and the result of the remediation.

(v) Testing measures, to include test questions and answers, individual student tests, student scores by student name, DPSST number and date of examination, and the overall class percentage.

(vi) Individual student records, to include evaluation forms, PQC qualification card, training records, and absence reports.

(vii) All skill sheets for every student completing some or all of the required skill sheets.

(7) Waiver. A person requesting a waiver of any course requirements is required to submit to the Department any supporting documents or pertinent expert testimony and evaluation requested. Any expense associated with providing such documentation, testimony or evaluation shall be borne by the person requesting the waiver or the requesting agency.

(8) Notwithstanding this rule, the Department may prescribe additional training for Basic certification, up to and including completion of the full Basic course, in situations in which previous periods of employment have been limited.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 181.640

Stats. Implemented: ORS 181.640

Hist.: PS 12, f. & ef. 12-19-77; PS 1-1979, f. 10-1-79, ef. 10-3-79; PS 1-1982, f. & ef. 7-2-82; PS 1-1983, f. & ef. 12-15-83; PS 1-1985, f. & ef. 4-24-85; Renumbered from 259-010-0030, PS 1-1990, f. & cert. ef. 2-7-90; PS 2-1995, f. & cert. ef. 9-27-95; PS 5-1997, f. 3-20-97, cert. ef. 3-25-97; PS 10-1997(Temp), f. & cert. ef. 11-5-97; BPSST 1-1998, f. & cert. ef. 5-6-98; BPSST 2-1998(Temp), f. & cert. ef. 5-6-98 thru 6-30-98; BPSST 3-1998, f. & cert. ef. 6-30-98; BPSST 11-2000, f. 11-13-00, cert. ef. 11-15-00; BPSST 13-2001(Temp), f. & cert. ef. 10-26-01 thru 4-10-02; BPSST 2-2002, f. & cert. ef. 2-6-02; BPSST 8-2002, f. & cert. ef. 4-3-02; BPSST 15-2002, f. & cert. ef. 7-5-02; DPSST 14-2003, f. & cert. ef. 12-22-03; DPSST 5-2004, f. & cert. ef. 4-23-04; DPSST 3-2007, f. & cert. ef. 1-12-06; DPSST 3-2007, f. & cert. ef. 1-12-07; DPSST 9-2008, f. & cert. ef. 7-15-08; DPSST 14-2008, f. & cert. ef. 10-15-08; DPSST 3-2009, f. & cert. ef. 4-8-09; DPSST 8-2009(Temp), f. & cert. ef. 9-15-09 thru 3-1-10; DPSST 15-2009, f. & cert. ef. 12-15-09; DPSST 3-2010, f. 4-12-10, cert. ef. 5-1-10; DPSST 2-2011, f. 3-23-11, cert. ef. 5-1-11; DPSST 13-2012(Temp), f. & cert. ef. 5-8-12 thru 10-1-12; DPSST 17-2012, f. & cert. ef. 8-24-12; DPSST 6-2013, f. & cert. ef. 3-8-13; DPSST 15-2013, f. & cert. ef. 6-25-13

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Rule Caption: Update NFPA 1003 Standard for Airport Fire Fighter Professional Qualifications.
Adm. Order No.: DPSST 16-2013
Filed with Sec. of State: 6-25-2013

Certified to be Effective: 6-25-13
Notice Publication Date: 6-1-2013
Rules Amended: 259-009-0062
Subject: Adopts NFPA 1003 standard, 2010 edition, relating to the professional qualifications of airport fire fighters.
Rules Coordinator: Linsay Hale—(503) 378-2431

259-009-0062
Fire Service Personnel Certification

(1) A fire service professional affiliated with an Oregon fire service agency may be certified by satisfactorily completing the requirements specified in section (2) of this rule: through participation in a fire service agency training program accredited by the Department; or through a course certified by the Department; or by evaluation of experience as specified in OAR 259-009-0063. The Department may certify a fire service professional who has satisfactorily completed the requirements for certification as prescribed in section (2) of this rule, including the Task Performance Evaluations (TPE) if applicable.

(2) The following standards for fire service personnel are hereby adopted by reference:

(a) The provisions of the NFPA Standard 1001, 2008 Edition, entitled "Fire Fighter Professional Qualifications";

(A) "Authority having jurisdiction" means the Department of Public Safety Standards and Training.

(B) Delete section 1.3.1.

NOTE: This references NFPA 1500.

(C) Delete section 2.2.

NOTE: This references NFPA 1500 and 1582.

(D) Entry Level Fire Fighter means an individual trained to the requirements of Section 2-1 Student Prerequisites, NFPA Standard 1403, 1997 Edition, entitled "Live Fire Training Evolutions" and the applicable safety requirements adopted by OR-OSHA. An individual trained to this level and verified so by the agency head is qualified to perform live-fire training exercises and to perform on the emergency scene under constant supervision. An Entry Level Fire Fighter should be encouraged to complete Fire Fighter I training within one year.

(E) Before an applicant can qualify for certification, the applicant must complete either a Task Performance Evaluation or a Department approved Task Book for Fire Fighter I and Fire Fighter II, signed off by the Agency Head or Training Officer.

(b) The provisions of the NFPA Standard 1002, 2009 Edition, entitled Standard for Fire Apparatus Driver/Operator Professional Qualifications," are adopted subject to the following definitions and modifications hereinafter stated:

(A) 5.1 General. The job performance requirements defined in Sections 5.1 and 5.2, must be met prior to certification as a Fire Service Agency Driver/Operator-Pumper.

(B) 6.1 General. The requirements of NFPA 1001 Fire Fighter I and NFPA 1002 Fire Apparatus Driver/Operator, as specified by the Department and the job performance requirements defined in Sections 6.1 and 6.2, must be met prior to certification as a Fire Service Agency Driver/Operator-Aerial.

(C) 7.1 General. The requirements of NFPA 1001 Fire Fighter I and NFPA 1002 Fire Apparatus Driver/Operator, as specified by the Department and the job performance requirements defined in Sections 7.1 and 7.2 must be met prior to certification as a Fire Service Agency Driver/Operator-Tiller.

(D) 8.1 General. The requirements of NFPA 1001 Fire Fighter I and NFPA 1002 Fire Apparatus Driver/Operator, as specified by the Department and the job performance requirements defined in Sections 8.1 and 8.2, must be met prior to certification as a Fire Service Agency Driver/Operator-Wildland Fire Apparatus.

(E) 9.1 General. The requirements of NFPA 1001 Fire Fighter II and NFPA 1002 Fire Apparatus Driver/Operator, as specified by the Department and the job performance requirements defined in Sections 9.1 and 9.2, must be met prior to certification as a Fire Service Agency Driver/Operator-Aircraft Rescue and Fire Fighting Apparatus (ARFF).

(F) 10.1 General. The requirements of NFPA 1002 Fire Apparatus Driver/Operator, as specified by the Department and the job performance requirements defined in Sections 10.1 and 10.2, must be met prior to certification as a Fire Service Agency Driver/Operator-Mobile Water Supply Apparatus.

(G) Delete "the requirements of NFPA 1500, Standard on Fire Department Occupational Safety and Health Program".

(H) All applicants for certification must complete either a Task Performance Evaluation or a Department approved Task Book for: Driver, Pumper Operator, Aerial Operator, Tiller Operator, Wildland Fire Apparatus Operator, Aircraft Rescue and Fire-Fighting Apparatus Operator or Mobile Water Supply Apparatus Operator and signed off by the Agency Head or Training Officer before an applicant can qualify for certification.

(c) The provisions of the NFPA Standards 1003, 2010 Edition, entitled "Standard for Airport Fire Fighter Professional Qualifications,"

(A) 6.1 General. Prior to certification as a Fire Service Agency NFPA 1003 Airport Fire Fighter, the requirements of NFPA 1001 Fire Fighter II as specified by the Department, and the job performance requirements defined in sections 5.1 through 5.4 must be met.

(B) All applicants for certification must complete a Department-approved Task Book for Airport Fire Fighter. The Task Book must be approved by the Agency Head or Training Officer before an applicant can qualify for certification.

(d) The provisions of NFPA Standard 1005, 2007 Edition, entitled "Marine Fire Fighting for Land Based Fire Fighters Professional Qualifications," are adopted subject to the following definitions and modifications:

(A) "Authority having jurisdiction" means the Department of Public Safety Standards and Training.

(B) Delete section 2.2.

NOTE: This references NFPA 1500.

(C) Delete sections of 2.4.

NOTE: This references NFPA 1000, NFPA 1081, NFPA 1405, NFPA 1670 and NFPA 1710.

(D) 5.1 General. Prior to certification as a Fire Service Agency NFPA 1005 Marine Land-Based Fire Fighter, the requirements of NFPA 1001 Fire Fighter II, as specified by the Department.

(E) All applicants for certification must complete a Department approved Task Book for: Marine Fire Fighting for Land Based Fire Fighters and signed off by the Agency Head or Training Officer before an applicant can qualify for certification.

(F) Transition Phase:

(i) An application for certification in Marine Fire Fighting for Land Based Fire Fighters must be submitted to the Department no later than June 30, 2009 to receive consideration for certification without having to complete a task book.

(ii) All applications received on or after July 1, 2009, will need to show completion of the approved task book.

(e) The provisions of the NFPA Standard No. 1031, Edition of (2009), entitled "Professional Qualifications for Fire Inspector and Plan Examiner" are adopted.

(A) All applicants for certification as an NFPA Fire Inspector I must:

(i) Successfully complete a Department approved Task Book; and

(ii) Furnish proof that they have passed an exam demonstrating proficiency in the model fire code adopted by the State of Oregon or an equivalent.

(B) All applicants for certification as an NFPA Fire Inspector II must:

(i) Hold a certification as a Fire Inspector I; and

(ii) Successfully complete a Department approved Task Book.

(C) All applicants for certification as an NFPA Fire Inspector III must:

(i) Hold a certification as a Fire Inspector II; and

(ii) Successfully complete a Department approved Task Book.

(D) Task books must be monitored by a Field Training Officer approved by the Department. The Field Training Officer must be certified at or above the level being monitored and have at least five (5) years inspection experience. The Department may approve other Field Training Officers with equivalent training, education and experience as determined by designated Department staff.

(f) The provisions of the NFPA Standard No. 1033, Edition of (2009), entitled "Professional Qualifications for Fire Investigator" are adopted subject to the following definitions and requirements:

(A) An individual must successfully complete a Department approved Task Book before the Department will administer a written examination for the Fire Investigator certification level. Exception: Anyone holding a valid IAAI Fire Investigator Certification, National Association of Fire Investigators (NAFI) certification, or Certified Fire Explosion Investigators (CFEI) certification is exempt from taking the Department's Fire Investigator written exam.

(B) A Department approved Field Training Officer must monitor the completion of a Task Book. The Field Training Officer must be certified at or above the level being monitored and have at least five (5) years fire investigation experience. Exception: The Department may approve a Field Training Officers with equivalent training, education and experience.

(g) The provisions of the NFPA Standard No. 1035, Edition of 2000, entitled "Professional Qualifications for Public Fire and Life Safety Educator" are adopted subject to the following definitions and modifications:

(A) Chapter 6 (Six) "Juvenile Firesetter Intervention Specialist I" and Chapter 7 (Seven) "Juvenile Firesetter Intervention Specialist II," Oregon-amended, shall be adopted with the following changes:

(i) Change the following definitions:

(I) 1-4.4 Change the definition of "Assessment" to read: "A structured process by which relevant information is gathered for the purpose of determining specific child or family intervention needs conducted by a mental health professional."

(II) 1-4.11 Change the title of "Fire Screener" to "Fire Screening" and the definition to read "The process by which we conduct an interview with a firesetter and his or her family using state approved forms and guidelines. Based on recommended practice, the process may determine the need for referral for counseling and/or implementation of educational intervention strategies to mitigate effects of firesetting behavior."

(III) 1-4.14 Include "insurance" in list of agencies.

(IV) 1-4.15 Change the definition to read: "...that may include screening, education and referral for assessment for counseling, medical services."

(V) 1-4.16 Change "person" to "youth" and change age from 21 to 18.

(VI) 1-4.17 Add "using state-approved prepared forms and guidelines."

(VII) 1-4.22 Add "...or by authority having jurisdiction."

(VIII) 1-4.24 Add "...or as defined by the authority having jurisdiction."

(ii) Under 6-1 General Requirements, delete the statement, "In addition, the person shall meet the requirements for Public Fire and Life Safety Educator I prior to being certified as a Juvenile Firesetter Intervention Specialist I."

(B) A task book shall be completed prior to certification as a Public Fire and Life Safety Educator I, II or III.

(C) A task book shall be completed prior to certification as a Public Information Officer.

(D) A task book shall be completed prior to certification as a Juvenile Firesetter Intervention Specialist I and II.

(h) The provisions of the NFPA Standard No. 1041, Edition of 2012, entitled "Standard for Fire Service Instructor Professional Qualifications," are adopted subject to the successful completion of an approved task book for NFPA Fire Instructor I, II and III.

(i) The provisions of the NFPA Standard 1021, 2009 Edition, entitled "Standards for Fire Officer Professional Qualifications," are adopted subject to the following definitions and modifications:

(A) 4.1 General. For certification as Fire Officer I, the candidate must be certified at NFPA 1001 Fire Fighter II, and NFPA 1041 Fire Instructor I, as defined by the Department, and meet the job performance requirements defined in Sections 4.1 through 4.7 of this Standard.

(i) Amend section 4.1.2 General Prerequisite Skills to include college courses or Department approved equivalent courses in the following areas of study: Communications, Math, Physics, Chemistry, or Fire Behavior and Combustion. Refer to the suggested course guide for detailed course, curriculum and training information.

(ii) All applicants for certification must complete either a Task Performance Evaluation or a Department approved Task Book for; NFPA Fire Officer I and signed off by the Agency Head or Training Officer before an applicant can qualify for certification.

(B) 5.1 General. For certification as NFPA Fire Officer II, the candidate must be certified as NFPA Fire Officer I, as defined by the Department, and meet the job performance requirements defined in Section 5.1 through 5.7 of the Standard.

(i) Amend section 5.1.2 General Prerequisite Skills to include college courses or Department approved equivalent courses in the following areas of study: Psychology or Sociology.

(ii) Amend section 5.3 Community and Government Relations to include State and Local Government or Department approved equivalent courses.

(iii) All applicants for certification must complete either a Task Performance Evaluation or a Department approved Task Book for NFPA Fire Officer II, and signed off by the Agency Head or Training Officer, before an applicant can qualify for certification.

(C) 6.1 General. For certification as NFPA Fire Officer III, the candidate must be certified as a NFPA Fire Officer II, NFPA, NFPA 1041 Fire Instructor II, as defined by the Department, and meet the job performance requirements defined in Sections 6.1 through 6.7 of the Standard.

(i) All applicants for certification must complete a Department approved Task Book for NFPA Fire Officer III, and signed off by the Agency Head or Training Officer, before an applicant can qualify for certification.

(D) 7.1 General. For certification as NFPA Fire Officer IV the candidate must be certified as NFPA Fire Officer III, as defined by the Department, and meet the job performance requirements in Sections 7.1 through 7.7 of the Standard.

(i) All applicants for certification must complete a Department approved Task Book for NFPA Fire Officer IV, and signed off by the Agency Head or Training Officer, before an applicant can qualify for certification.

(j) Hazardous Materials Responder (DPSST-P-12 1/96).

(k) Fire Ground Leader.

(A) This is a standard that is Oregon-specific.

(B) An applicant applying for Fire Ground Leader must first be certified as an NFPA Fire Fighter II.

(C) An applicant applying for Fire Ground Leader must document training in all of the following areas:

(i) Building Construction: Non-Combustible and Combustible;

(ii) Emergency Service Delivery;

(iii) Fire Behavior;

(iv) Fire Ground Safety; and

(v) Water Supply Operations.

(D) All applicants for certification must complete a Task Performance Evaluation or a Department-approved Task Book for Fire Ground Leader. The Evaluation or Task Book must be approved by the Agency Head or Training Officer before an applicant can qualify for certification.

(l) Advanced Wildland Interface Fire Fighter (FFT1).

(A) This standard includes NWCG Wildland Fire Fighter Type 1.

(B) An individual applying for Wildland Interface Fire Fighter (FFT1) must be certified as Wildland Interface Fire Fighter (FFT2) prior to applying for Wildland Interface Fire Fighter (FFT1) and must document training in all of the following areas at the time of application:

(i) S-131 Firefighter Type I;

(ii) S-133 Look Up, Look Down, Look Around; and

(iii) Completion of the NWCG NWCG Firefighter Type 1 (FFT1)/Incident Commander Type 5 (ICT5) Task Book.

(m) Wildland Interface Fire Fighter (FFT2).

(A) This standard includes NWCG Wildland Fire Fighter Type 2.

(B) An individual applying for Wildland Interface Fire Fighter (FFT2) must document training in all of the following areas at the time of application:

(i) S-130 Fire Fighter Training;

(ii) S-190 Wildland Fire Behavior;

(iii) L-180 Human Factors on the Fireline; and

(iv) I-100 Introduction to ICS.

(n) Wildland Interface Engine Boss.

(A) This is an NWCG standard.

(B) An individual applying for Wildland Interface Engine Boss must be certified as Wildland Interface Fire Fighter prior to applying for Wildland Interface Engine Boss and must document training in all of the following areas at the time of application:

(i) I-200 Basic Incident Command;

(ii) S-230 or S-231 Crew Boss (Single Resource);

(iii) S-290 Intermediate Wildland Fire Behavior; and

(iv) Completion of the Task Book for NWCG Single Resource Boss Engine.

(o) Wildland Interface Crew Boss.

(A) This is an NWCG standard.

(B) An individual applying for Wildland Interface Crew Boss must be certified as Wildland Interface Fire Fighter prior to applying for Wildland Interface Crew Boss and must document training in all of the following areas at the time of application:

(i) I-200 Basic Incident Command;

(ii) S-230 Crew Boss (Single Resource);

(iii) S-290 Intermediate Wildland Fire Behavior; and

(iv) Completion of the Task Book for NWCG Single Resource Boss Crew.

(p) Wildland Interface Strike Team Leader Engine.

(A) This is an NWCG standard.

(B) An individual applying for Wildland Interface Strike Team Leader Engine must be certified as Wildland Interface Engine Boss prior to apply-

ing for Wildland Interface Strike Team/Leader Engine and must document training in all of the following areas at the time of application:

(i) S-215 Fire Operations in the WUI;

(ii) S-330 Task Force/Strike Team Leader;

(iii) I-300 Intermediate ICS; and

(iv) Completion of the Task Book for NWCG Strike Team Leader Engine.

(q) Wildland Interface Strike Team Leader Crew.

(A) This is an NWCG standard.

(B) An individual applying for Wildland Interface Strike Team Leader Crew must be certified as Wildland Interface Crew Boss prior to applying for Wildland Interface Strike Team Leader Crew and must document training in all of the following areas at the time of application:

(i) S-215 Fire Operations in the WUI;

(ii) S-330 Task Force/Strike Team Leader;

(iii) I-300 Intermediate ICS; and

(iv) Completion of the Task Book for NWCG Strike Team Leader Crew.

(r) Wildland Interface Structural Group Supervisor.

(A) This is an Oregon standard.

(B) An individual applying for Wildland Interface Structural Group Supervisor must be certified as Wildland Interface Strike Team Leader Engine prior to applying for certification as Wildland Structural Interface Group Supervisor and must document training in all of the following areas at the time of application:

(i) S-390 Introduction to Wildland Fire Behavior Calculations;

(ii) S-339 Division/Group Supervisor; and

(iii) Completion of the Task Book for NWCG Group Supervisor.

(s) Wildland Interface Division/Group Supervisor.

(A) This is an NWCG standard.

(B) An individual applying for Wildland Interface Division/Group Supervisor must be certified as Wildland Interface Strike Team Leader Engine and a Wildland Interface Strike Team Leader Crew prior to applying for certification as Wildland Interface Division/Group Supervisor and must document training in all of the following areas at the time of application:

(i) S-390 Introduction to Wildland Fire Behavior Calculations;

(ii) S-339 Division/Group Supervisor; and

(iii) Completion of the Task Book for NWCG Division/Group Supervisor.

(t) Maritime Fire Service Operator Standards Professional Qualifications (October, 1999) and completion of an approved task book. Historical Recognition:

(A) The application shall be submitted with the Fire Chief or designee's signature attesting to the skill level and training of the applicant.

(B) The application must be submitted to the Department no later than October 1, 2004, to receive certification for Maritime Fire Service Operator without having to complete the task book.

(C) All applications received after October 1, 2004, will need to show completion of the approved task book.

(u) Certification guide for Wildland Fire Investigator (August, 2005).

(v) The provisions of the 2008 Edition of NFPA 1006 entitled, "Standards for Technical Rescuer Professional Qualifications" are adopted subject to the following modifications:

(A) The "Authority Having Jurisdiction" means the local or regional fire service agency.

(B) Historical Recognition:

(i) Applicants who currently hold active Department of Public Safety Standards and Training NFPA Surface Water Rescue Technician and NFPA Rope Rescue levels of certification may apply for NFPA Swiftwater Rescue level of certification.

(ii) The NFPA Technical Rescuer application for certification under (i) above must be submitted to the Department of Public Safety Standards and Training on or before December 30, 2011.

(C) Instructors:

(i) Curriculum must be certified by the Department to meet NFPA 1006 standards.

(ii) An instructor delivering training under a fire service agency's accreditation agreement must be a certified technician in that specialty rescue area.

(D) Task Books:

(i) A task book must be completed for each of the eleven specialty rescue areas applied for.

(ii) Only a certified technician in that specialty rescue area can sign off on the task book.

(iii) The requirements in Chapters 4 and 5 need only to be met once for all eleven specialty rescue areas.

(w) Urban Search and Rescue.

(A) This is a standard that is Oregon-specific.

(B) The following eleven (11) specialty Urban Search and Rescue (USAR) certifications are adopted:

(i) Task Force Leader;

(ii) Safety Officer;

(iii) Logistics Manager;

(iv) Rescue Team Manager;

(v) Rescue Squad Officer;

(vi) Rescue Technician;

(vii) Medical Technician;

(viii) Rigging Technician;

(ix) Search Team Manager;

(x) Search Squad Officer;

(xi) Search Technician.

(C) An applicant applying for any USAR certification(s) must complete the appropriate application(s) attesting to completion of the required training.

(x) The provisions of the NFPA Standard 472, 2008 Edition, entitled "Standard for Hazardous Materials and Weapons of Mass Destruction" are adopted subject to the following definitions and modifications hereinafter stated:

(A) Hazardous Materials Technician: All applicants for certification must first certify as an Operations Level Responder and complete a Department approved Task Book, signed off by the Agency Head or Training Officer, before an applicant can qualify for certification.

(B) Hazardous Materials Safety Officer: All applicants for certification must first certify as a Hazardous Materials Technician and complete a Department approved Task Book, signed off by the Agency Head or Training Officer, before an applicant can qualify for certification. This certification level includes, but is not limited to, the following course work:

(i) Analyzing the Incident;

(ii) Planning the Response;

(iii) Implementing the Planned Response;

(iv) Evaluating the Progress.

(C) Incident Commander: The level of certification formerly known as "On-Scene Incident Commander" is now known as "Incident Commander." The Incident Commander correlates directly with NFPA 472. All applicants for certification must first certify as an Operations Level Responder.

(D) Operations Level Responder: The level of certification formerly known as "First Responder" is now known as "Operations Level Responder." The Operations Level Responder correlates directly with NFPA 472. Successful completion of skills sheets or task performance evaluations (TPE) must be met prior to certification as an Operations Level Responder.

(y) Specialty Levels of Certification. All applicants for specialty levels of certification must first certify as a Hazardous Materials Technician.

(A) The following four (4) specialty certifications are adopted:

(i) Cargo Tank Specialty;

(ii) Intermodal Tank Specialty;

(iii) Marine Tank Vessel Specialty;

(iv) Tank Car Specialty;

(B) Successful completion of task performance evaluations (TPE) must be met prior to obtaining a specialty level of certification.

(3) Task performance evaluations, where prescribed, shall be required prior to certification. Such examinations shall be conducted in the following manner:

(a) Task performance competency shall be evaluated by three people nominated by the employing fire service agency's Chief Officer for approval by the Department or its designated representative.

(b) The employing fire service agency's equipment and operational procedures shall be used in accomplishing the task performance to be tested.

(c) Specific minimum testing procedures, as provided by the Department, shall be used for administration of the evaluation.

(d) The training officer for an accredited fire service agency training program must notify the Department or its designated representative prior to performing a Task Performance Evaluation.

(e) At the request of the fire chief, a representative of the Department will be designated to monitor the task performance evaluation for personnel from a fire service agency whose training program is not accredited.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 181.640

Stats. Implemented: ORS 181.640
Hist.: BPSST 22-2002, f. & cert. ef. 11-18-02; DPSST 11-2003 f. & cert. ef. 7-24-03; DPSST 13-2003(Temp), f. & cert. ef. 10-27-03 thru 3-31-04; DPSST 3-2004(Temp), f. & cert. ef. 4-9-04 thru 10-1-04; DPSST 8-2004, f. & cert. ef. 4-23-04; DPSST 2-2006, f. & cert. ef. 1-24-06; DPSST 9-2006 f. & cert. ef. 7-7-06; DPSST 14-2006, f. & cert. ef. 10-13-06; DPSST 16-2006, f. & cert. ef. 11-20-06; DPSST 2-2007, f. & cert. ef. 1-12-07; DPSST 10-2008, f. & cert. ef. 7-15-08; DPSST 7-2009, f. & cert. ef. 7-13-09; DPSST 12-2009, f. & cert. ef. 10-15-09; DPSST 16-2009(Temp), f. & cert. ef. 12-15-09 thru 6-11-10; DPSST 5-2010, f. 6-11-10, cert. ef. 6-14-10; DPSST 11-2010, f. & cert. ef. 11-12-10; DPSST 11-2010, f. & cert. ef. 11-12-10; DPSST 3-2011, f. 3-28-11, cert. ef. 5-1-11; DPSST 7-2012, f. & cert. ef. 3-28-12; DPSST 21-2012, f. & cert. ef. 10-1-12; DPSST 8-2013, f. & cert. ef. 3-26-13; DPSST 16-2013, f. & cert. ef. 6-25-13

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Department of Revenue
Chapter 150

Rule Caption: Urban renewal property tax categorization and calculation.
Adm. Order No.: REV 5-2013(Temp)
Filed with Sec. of State: 7-11-2013
Certified to be Effective: 7-15-13 thru 1-1-14
Notice Publication Date:
Rules Amended: 150-457.440(9)
Subject: This temporary rule amends OAR 150-457.440(9) to remove language stating that assessors must include urban renewal division of tax and special levy revenue in the "general government" category under Article XI, s. 11b of the Oregon Constitution and ORS 310.510 when calculating property taxes.
Rules Coordinator: Deanna Mack—(503) 947-2082

150-457.440(9)
Urban Renewal Certification, Calculation and Distribution

(1) Definitions: For purposes of this rule:

(a) "Consolidated billing tax rate" means:

(A) For reduced rate plans, the total of all taxing district billing tax rates used to extend taxes, after any adjustments to reflect tax offsets, but does not include:

(i) Any urban renewal special levy rate;

(ii) Any local option tax rate if the tax was approved by the voters after October 6, 2001;

(iii) Any exempt bonded indebtedness tax rate (except for Portland Police and Fire Pension and Disability bonds, if so issued) approved by the voters after October 6, 2001; or

(iv) The portion of Portland Public School District's permanent rate levy described in OAR 150-457.440(2) section (13) that the district notifies the assessor to exempt from division of tax.

(B) For standard rate plans, the total of all taxing district billing tax rates used to extend taxes, after any adjustments to reflect tax offsets, but does not include any urban renewal special levy rate.

(b) "Division of tax" means:

(A) For purposes of determining the amount of division of tax to use in tax calculation, the amount calculated by multiplying the tax rate for each taxing district levy in a code area by the increment value used in that code area and summing the product for all code areas in the plan area. Only those taxing district tax rates that are part of the consolidated billing tax rate for that plan are used for this calculation.

(B) For purposes of computing the estimate of the division of tax portion of the maximum authority for existing plans, the amount calculated by multiplying the consolidated billing tax rate for the code area by the increment value used in the code area and summing the product for all code areas in the plan. Only those taxing district tax rates that are part of the consolidated billing tax rate are used for this calculation.

(c) "Division of tax rate" means the rate determined for each taxing district levy within the consolidated billing tax rate for an urban renewal plan. This rate is calculated by dividing the division of tax amount by the taxable assessed value of any shared property for that district. This is the rate that is multiplied by the taxable assessed value of any shared property of the district to determine the amount of division of tax extended before compression on that property from that levy for that plan.

(d) "Existing plan" means an urban renewal plan that provides for a division of ad valorem property taxes as described under ORS 457.420 to 457.460, adopted by ordinance before December 6, 1996, that meets the conditions of ORS 457.010(5).

(e) "Frozen value" means:

(A) The assessed value of the property in an urban renewal plan area at the plan's inception, as certified by the assessor under ORS 457.430 and OAR 150-457.430; or

(B) The value stated by the agency in the notice to the assessor pursuant to ORS 457.455(2).

(f) "Increment value" means the positive value obtained by subtracting the frozen value in a plan area from the total assessed value in a plan area, calculated code area by code area. Negative results are disregarded, resulting in the code area having zero increment value.

(g) "Increment value used" means:

(A) For an Option Three existing plan, that portion of the increment value in the plan area necessary to raise the amount of division of tax stated in the ordinance selecting Option Three that was adopted by the urban renewal agency under ORS 457.435, or a lesser amount of increment value specified by the agency under paragraph (B) of this subsection.

(B) For plans for which the urban renewal agency specifies, pursuant to ORS 457.455(1) or 457.470, an amount of assessed value less than the full increment amount that is available, the amount of increment value specified. The assessor must apportion to the code areas in the plan area the amount of increment specified by the agency.

(C) For all other plans "increment value used" means "increment value."

(h) "Maximum authority" means the limitation on the amount of revenue to be raised for the year for an existing plan area, as described in ORS 457.435(3). Only plans that are existing plans have a maximum authority amount. The maximum authority is adjusted each year to reflect growth in assessed value within the plan area as provided in ORS 457.435(3)(b).

(i) "Rate computation value" means the total assessed value in an ad valorem taxing district, plus the value of Fish and Wildlife properties and of Non-Profit Housing properties, minus urban renewal increment value used.

(j) "Reduced rate plan" means any urban renewal plan that is:

(A) Adopted before December 6, 1996, designated as an existing plan, and also designated as an Option One plan;

(B) Adopted before December 6, 1996, was an existing plan designated as an Option One plan on October 6, 2001, and was substantially amended as described in ORS 457.085(2)(i)(A) or (B) on or after October 6, 2001;

(C) Adopted on or after October 6, 2001; or

(D) Adopted before December 6, 1996, and the governing body of the city or county that adopted the plan irrevocably elects to change the plan from being a standard rate plan to a reduced rate plan, pursuant to ORS 457.445, and provides the assessor by July 15 of the first tax year it is effective, a copy of the resolution or ordinance making the election.

(k) "Shared property" is property that is both within a taxing district that overlaps an urban renewal plan area, and within the boundaries of a municipality that activated an urban renewal agency. It also includes any area of a plan that extends beyond the boundaries of the activating municipality for that plan.

(l) "Standard rate plan" means an urban renewal plan that is not a reduced rate plan.

(2) Urban renewal agencies making use of tax increment financing must certify their tax increment financing request to the county assessor under ORS 310.060 and pursuant to OAR 150-457.440(2) by July 15 using Department of Revenue Form UR-50 Notice to Assessor for the current tax year. The assessor may, for cause, grant an extension of this date up to October 1.

(3) The assessor must separately calculate the estimated revenue to be raised from each plan area within the territory of a taxing district. To make this calculation the assessor must:

(a) Determine whether the plan is a standard rate plan or a reduced rate plan. Calculate the consolidated billing tax rate accordingly;

(b) Determine the maximum authority of an existing plan by multiplying last year's maximum authority by the percentage growth in plan increment value this year as provided in ORS 457.435(3);

(c) Determine the estimated amount to be raised by the division of tax for the plan. For each code area within the plan area, multiply the consolidated billing tax rate by the increment value used in the code area. Add the amounts of all code areas within a plan; and

(d) Determine the maximum amount of the special levy, if any, for each existing urban renewal plan by subtracting the estimated amount to be raised by the division of tax from the maximum authority of the plan. The maximum special levy cannot be less than zero.

(4) If the plan is an Option One plan:

(a) The assessor must calculate the maximum amount of urban renewal taxes to be raised through the division of tax as provided in section (3) of this rule, or a lesser amount of division of tax using the increment value

used that is specified by the agency, according to the agency's certification on Form UR-50.

(b) If the agency requests one hundred percent of the division of tax and a special levy amount on Form UR-50, the assessor must calculate and extend a special levy for the amount certified, provided the total amount of the special levy plus the estimated division of tax amount is equal to or less than the maximum authority of the plan as determined under subsection (3)(b) of this rule.

(c) If the total of the special levy certified for the plan area plus the estimated division of tax amount computed for the plan by the assessor exceeds the maximum authority of the plan, the assessor must reduce the amount of the special levy until the total of the special levy and the estimated division of tax amount equals the maximum authority for the plan.

(d) If, instead of requesting one hundred percent of division of tax, an agency certifies on Form UR-50 an amount of increment value used, the assessor must not calculate a special levy for that plan.

(5) If the plan is an Option Three plan:

(a) The agency must certify on Form UR-50 the amount stated in the ordinance selecting Option Three as the amount to be collected through the division of taxes, or the amount of increment value that the agency estimates will raise some lesser amount of division of tax.

(b) If the agency certifies the amount of division of tax stated in the ordinance selecting Option Three, the assessor must calculate the amount of increment value necessary to raise the division of tax amount stated in the ordinance. The amount calculated by the assessor is the increment value used.

(c) If the agency certifies the amount of increment value that the agency estimates will raise some lesser amount of division of tax, the amount specified is the increment value used.

(d) If the agency certifies a special levy and certifies the amount of division of tax stated in the ordinance selecting Option Three, and the total special levy plus the estimated division of tax amount computed for the plan by the assessor exceeds the maximum authority of the plan, the assessor must reduce the special levy until the total of the two equals the maximum authority.

(e) If the agency certifies a special levy and certifies an amount of increment value used that the agency estimates will raise an amount of division of tax that is less than the amount stated in the ordinance selecting Option Three, and the total of the special levy plus the estimated division of tax amount computed by the assessor using that amount of increment value exceeds the total that would have been available under the plan's maximum authority had the agency certified the amount of division of tax stated in the ordinance selecting Option Three, the assessor must reduce the special levy amount so that the total of the special levy and the estimated division of tax equals the total that would have been available under the plan's maximum authority, had the agency certified the amount of division of tax stated in the ordinance selecting Option Three.

(6) If the plan is not an existing plan, the agency must certify on Form UR-50:

(a) One hundred percent of the amount of division of tax; or

(b) The amount of increment value used that the agency estimates will raise some lesser amount of division of tax, pursuant to ORS 457.455(1) or 457.470.

(7) The assessor must:

(a) Apportion the increment value used to the code areas in the plan area in the same proportions as the increment value is distributed among those code areas.

(b) If the full increment value in a code area is less than the amount of increment value used that is apportioned to the code area under subsection (7)(a) of this rule, the assessor must calculate the division of tax using the full increment value. No increment value is then used in calculating the taxes of the ad valorem taxing districts for the year.

(c) If the full increment value exceeds the amount of the increment value used, the assessor must use the remaining increment value in calculating the taxes of the ad valorem taxing districts for the current year.

(8) The assessor must:

(a) Use the rate computation value in calculating taxes for a taxing district that has an urban renewal plan area within its boundaries and whose rate is part of the consolidated billing tax rate for the plan.

(b) Calculate the urban renewal special levy tax rate for each plan area using the current year taxable value of all taxable property in the municipality that adopted the plan and any portion of the urban renewal plan area outside of the municipality. Current year taxable value includes the value of Non-profit Housing properties, Fish and Wildlife properties and urban renewal increment value.

(c) Calculate urban renewal special levy tax rates on a plan area by plan area basis. If one plan area of an agency extends beyond the boundary limits of the activating municipality, only the special levy rate for that plan area is extended beyond the boundaries of the municipality.

(d) Unless otherwise specifically provided by law, no tax offset applies to the special levy rate.

(9) The assessor must determine the tax rate for each code area for each tax levy that an ad valorem district certifies as follows:

(a) Determine the rate certified by the district for tax rate levies or calculate a tax rate for dollar amount levies;

(b) Subtract any offsets as applicable; and

(c) Subtract any division of tax rate for that district applicable to that code area from the result of subsection (9)(b) of this rule.

(10) The assessor must calculate a total division of tax rate for each code area. This is the total of the division of tax rates from all of the levies from all taxing districts with shared property in that code area, if such rates are in the consolidated billing tax rate.

(11) The division of tax rate may have two components. One is the total of rates derived from any local option tax levies. The other component is the total of rates derived from any other levies. The assessor must treat the amount of taxes derived from each of the two total rates separately for purposes of determining compliance with the limitations of section 11(b) Article XI of the Oregon Constitution.

(12) The assessor must calculate the amount of tax on each account that is distributed to each urban renewal agency as follows:

(a) For each property within a shared property area the assessor must calculate the division of tax amount extended by multiplying the taxable assessed value of the account by the division of tax rate for each plan area.

(b) For each property within a shared property area that has an urban renewal special levy, the assessor must calculate the amount extended for the special levy by multiplying the taxable assessed value of the account by the rate calculated for each urban renewal special levy.

(c) If taxes exceed the limitations in either category of section 11(b) Article XI of the Oregon Constitution, the assessor must reduce the taxes to the category limit. The division of tax portion derived from local option levies must be reduced proportionately with all other similarly categorized local option levies before any other taxes in the category are reduced.

(13) The special levy and the division of tax must be imposed on all taxable property in the municipality that activated the urban renewal agency and any portion of the urban renewal plan area outside of the municipality that is shared property for that plan.

(14) The tax statement must display at a minimum for each agency, under the applicable limitation category, the total combined dollar amount imposed for the urban renewal special levy and the division of tax for that account.

(15) In preparing the percentage distribution schedule under ORS 311.390, the tax collector must use the dollar amount generated for urban renewal division of tax and the dollar amount imposed for urban renewal special levy for each urban renewal agency.

NOTE: The publication(s) referred to or incorporated by reference in this rule are available from the Department of Revenue pursuant to ORS 183.360(2) and 183.355(1)(b).

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 305.100 & 457.470

Stats. Implemented: ORS 457.440, 457.445 & 457.470

Hist.: REV 13-1999, f. 12-30-99, cert. ef. 12-31-99; REV 1-2002, f. & cert. ef. 5-23-02; REV 7-2008, f. 8-29-08, cert. ef. 8-31-08; REV 11-2010, f. 7-23-10, cert. ef. 7-31-10; REV 5-2013(Temp), f. 7-1--13, cert. ef. 7-15-13 thru 1-1-14

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Department of Transportation
Chapter 731

Rule Caption: Modifies provisions for submission of unsolicited proposals to the Oregon Innovative Partnerships Program

Adm. Order No.: DOT 2-2013

Filed with Sec. of State: 6-21-2013

Certified to be Effective: 6-21-13

Notice Publication Date: 1-1-2013

Rules Amended: 731-070-0050

Subject: OARs 731-070-0050 through 731-070-0230 govern the process by which private entities or units of government may submit unsolicited proposals for transportation projects under the Oregon Innovative Partnerships Program (OIPP). Recent experience has revealed that when an unsolicited proposal is submitted on a project that has progressed considerably through ODOT's project development process, it can be disruptive and expensive to change course

mid-stream. ODOT has amended its rule to restrict submission of unsolicited proposals in certain circumstances.
Rules Coordinator: Lauri Kunze—(503) 986-3171

731-070-0050
Submission of Unsolicited Proposal

(1) Unless prequalification is required under OAR 731-070-0350, any private entity or unit of government may submit an unsolicited Conceptual or Detailed Proposal for a Transportation Project to ODOT for consideration under the OIPP. The proposer shall prominently label the proposal as either a Conceptual Proposal or Detailed Proposal, as appropriate.

(2)(a) A proposal review fee in the amount prescribed by OAR 731-070-0055(1)(a) must accompany any unsolicited Conceptual Proposal submitted by a private entity or unit of government.

(b) A proposal review fee in the amount prescribed by OAR 731-070-0055(1)(c) must accompany any unsolicited Detailed Proposal submitted by a private entity or unit of government.

(3) The proposer shall submit 20 copies, individually identified, of any unsolicited proposal in addition to the proposal bearing the signature of the authorized representative. The original proposal, required copies and processing fee shall be delivered to the Director or his designee.

(4) ODOT will consider an unsolicited proposal only if the proposal:

(a) Is unique or innovative in comparison with and is not substantially duplicative of other transportation system projects included in the state transportation improvement program within the Department or, if it is similar to a project in the state transportation improvement program, the project has not been fully funded by ODOT or any other public entity as of the date the proposal is submitted, or the proposal offers an opportunity to materially advance or accelerate the implementation of the project. Unique or innovative features which may be considered by ODOT in evaluating such a proposal may include but are not limited to unique or innovative financing, construction, design, schedule or other project components as compared with other projects or as otherwise defined by ODOT rules or regulations; and

(b) Includes all information required by and is presented in the format set out in OAR 731-070-0060. Such information shall include a list of any proprietary information included in the proposal that the proposer considers protected trade secrets or other information exempted from disclosure under ORS 367.803(5) and (6) and OAR 731-070-0280 and 0290.

(5) ODOT will not consider an unsolicited proposal for a project involving another state or local government unit of another state unless ODOT and the appropriate representative of the other state or of the local government unit of the other state have entered into an agreement that permits the acceptance of unsolicited proposals for such a project.

(6) ODOT will not consider an unsolicited proposal for a project that has been incorporated in the Statewide Transportation Improvement Program (STIP) as approved by the Oregon Transportation Commission, and for which funding is fully committed, if the proposal is submitted later than July 1 of the design year designated in the STIP or, if no design year is designated, July 1 of the year that is two years prior to the construction year designated in the STIP.

Stat. Auth.: ORS 184.616, 184.619 & 367.824
Stat. Implemented: ORS 367.800 - 367.824
Hist.: DOT 5-2004, f. & cert. ef. 8-26-04; DOT 4-2009, f. & cert. ef. 12-22-09; DOT 2-2013, f. & cert. ef. 6-21-13

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Department of Transportation, Driver and Motor Vehicle Services Division
Chapter 735

Rule Caption: Proof of Compliance with Financial Responsibility Requirements
Adm. Order No.: DMV 9-2013(Temp)
Filed with Sec. of State: 6-21-2013
Certified to be Effective: 6-21-13 thru 12-17-13
Notice Publication Date:
Rules Amended: 735-050-0120
Subject: OR Law 2013, Chapter 108 (HB 2107) amends ORS 742.447 to expand how an insurance company may provide proof of motor vehicle insurance by authorizing an insurance company to provide proof by either issuing an insurance card or by issuing proof electronically when agreed to by the insured. DMV temporarily amended OAR 735-050-0120 to add electronic proof as one of the means to provide proof of compliance with financial responsibility requirements. The amendments also clarify what constitutes proof of compliance with financial responsibility requirements for purposes of ORS 806.011 and ORS 806.012.
Rules Coordinator: Lauri Kunze—(503) 986-3171

735-050-0120
Proof of Compliance With Financial Responsibility Requirements

For purposes of ORS 806.011 and 806.012, any of the following constitutes proof of compliance with financial responsibility requirements" that must be carried in the motor vehicle covered by such proof:

(1) Insurer provided proof of motor vehicle insurance issued as an insurance card or through electronic means.

(2) An unexpired motor vehicle liability insurance policy for the particular vehicle that meets the standards set forth in ORS 806.080;

(3) An unexpired motor vehicle liability insurance binder issued by the insurance carrier or its authorized insurance producer (agent) for the particular vehicle that meets the standards set forth in ORS 806.080;

(4) A letter signed by a representative from an insurance carrier or its authorized agent, on the insurance carrier's or agent's letterhead, that verifies current insurance coverage;

(5) A certificate of self insurance issued by the Driver and Motor Vehicle Services Division of the Department of Transportation (DMV) under ORS 806.130 naming the owner of the particular vehicle; or

(6) A displayed Oregon dealer plate unless the dealership does not sell motorized vehicles and has completed a "Certificate of Exemption from Vehicle Liability Insurance for Vehicle Dealer," DMV Form 735-7024.

Stat. Auth.: ORS 184.616, 184.619, 806.011 & 806.012
Stats. Implemented: ORS 806.011 & 806.012
Hist.: DMV 3-1994, f. & cert. ef. 7-21-94; DMV 22-2002, f. 11-18-02, cert. ef. 1-1-03; DMV 14-2003, f. 10-24-03, cert. ef. 1-1-04; DMV 20-2003, f. 12-15-03 cert. ef. 1-1-04; DMV 23-2009, f. 12-22-09, cert. ef. 1-1-10; DMV 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

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Rule Caption: Proof of Treatment Completion Required for Reinstatement of DUII Suspension
Adm. Order No.: DMV 10-2013(Temp)
Filed with Sec. of State: 6-21-2013
Certified to be Effective: 6-21-13 thru 12-17-13
Notice Publication Date:
Rules Amended: 735-070-0085
Subject: Section 2, Chapter 9, Oregon Laws 2012 requires a person to provide proof of completion of a treatment program before driving privileges may be reinstated for a suspension upon conviction for driving under the influence of intoxicants (DUII), unless DMV waives this requirement for good cause. Chapter 233, Oregon Laws 2013 (HB 2121) amends Section 2, Chapter 9, Oregon Laws 2012 to specify in statute the exemptions from the requirement for such proof and repeals the waiver for good cause. DMV has amended OAR 735-070-0085(3) to implement these statutory changes. DMV proposes to further amend this rule to specify that a DUII Treatment Completion Certificate, DMV form 735-6821, is the only form of proof that will be accepted by DMV.
Rules Coordinator: Lauri Kunze—(503) 986-3171

735-070-0085
Proof of Treatment Completion Required for Reinstatement of DUII Suspension

(1) Except as provided in section (3) of this rule, a person whose driving privileges are suspended due to a conviction in an Oregon court of driving under the influence of intoxicants (DUII) must provide as proof that the person completed a treatment program to which the person was referred under ORS 813.021, a DUII Treatment Completion Certificate (Certificate), DMV Form 735-6821. The Certificate must be completed by an authorized representative of an Oregon DUII treatment program approved by the Director of the Oregon Health Authority (OHA) or by an authorized representative of OHA on behalf of an Oregon DUII treatment provider or an out-of-state DUII treatment provider.

(2) If the person has more than one suspension of driving privileges resulting from DUII convictions, the Certificate required under section (1) of this rule is sufficient for reinstatement of all DUII suspensions with arrest dates that were before the date treatment was completed. For purposes of this section, the Certificate must show the date treatment was completed.

(3) If the person does not provide the proof described in section (1) of this rule, DMV will not reinstate driving privileges following a suspension for DUII unless:

(a) The person submits an order from the circuit court of the county in which the person was convicted showing that the person has taken sufficient steps to satisfy the requirement under ORS 813.021 to complete a treatment program;

(b) It has been 15 years or more since the person's last DUII conviction in an Oregon court; or

(c) The suspension of driving privileges resulted from a conviction in another jurisdiction for the statutory counterpart to ORS 813.010 (DUII).

Stat. Auth.: ORS 184.616, 184.619, 802.010, ORS 809.380 OL 2012, Ch. 9
Stats. Implemented: OL 2012, Ch. 9; OL 2013, Ch. 233
Hist.: DMV 5-1994, f. & cert. ef. 7-21-94; DMV 4-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMV 10-2012, f. & cert. ef. 7-19-12; DMV 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

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Department of Transportation, Motor Carrier Transportation Division
Chapter 740

Rule Caption: Intrastate household goods transportation regulations
Adm. Order No.: MCTD 5-2013
Filed with Sec. of State: 6-20-2013
Certified to be Effective: 6-20-13
Notice Publication Date: 5-1-2013
Rules Adopted: 740-060-0035, 740-060-0085, 740-060-0090
Rules Amended: 740-060-0010, 740-060-0020, 740-060-0040, 740-060-0045, 740-060-0055, 740-060-0060, 740-060-0070, 740-060-0080, 740-060-0100, 740-060-0110
Rules Repealed: 740-060-0030, 740-060-0040(T), 740-060-0080(T)
Subject: OAR chapter 740, division 60 rules govern the transportation of intrastate household goods. The rule changes are to clarify the scope and intent of the rules, reflect current practices and provide uniformity for safety regulations. Rule amendments, adoptions and repeal in this rulemaking action include the following: General Information Bulletin for Moving Household Goods in Oregon was moved to a separate publication; the adoption of three new rules related to cargo insurance and valuation declaration, hourly rate local moves and hourly rate distance moves; provision of estimates; criminal background checks; fee structure; and cartage areas exempt from economic regulation.
Rules Coordinator: Lauri Kunze—(503) 986-3171

740-060-0010
Information for Shippers and General Information Bulletin for Moving Household Goods in Oregon

(1) As used in division 60 rules, the term shipper refers to the owner of the household goods, or the owner's representative. The term carrier refers to the authorized intrastate for-hire motor carrier of household goods.

(2) Each carrier must give every prospective shipper an information bulletin titled General Information Bulletin for Moving Household Goods in Oregon ODOT form #735-9943.

(3) The text of the information bulletin, "General Information Bulletin for Moving Household Goods in Oregon," ODOT form # 735-9943 includes the following information:

(a) Estimates;
(b) Changes to estimates;
(c) Underestimates;
(d) Bills of Lading:
(e) Inventories;
(f) Packing, delivery and inspection;
(g) Storage needs;
(h) Ready to assemble furniture;
(i) Levels of protection and valuation options for household goods;
(j) Payment to mover;
(k) Loss or damage claims; and
(L) Complaints.

(4) The Mandatory Receipt must contain the following statements:

(a) Acknowledgement of receipt of General Information Bulletin for Moving Household Goods in Oregon;

(b) Final charges for services are based on rates that have been approved by ODOT and published in a tariff regardless of any estimate of service provided by the carrier.

(5) Each carrier must request the shipper to sign and date a Mandatory Receipt to acknowledge receipt of the information bulletin. The signed copy of the Mandatory Receipt must be retained for three years as a part of the carrier's documentation for the move.

Stat. Auth.: ORS 184.616, 184.619, 823.011, 825.232
Stats. Implemented: ORS 825.202, 825.204, 825.224
Hist.: PUC 156, f. 8-6-73, ef. 8-15-73 (Order No. 73-507); Renumbered from 860-39-005; PUC 9-1986(Temp), f. & ef. 8-19-86 (Order No. 86-831); PUC 12-1986, f. & ef. 10-2-86 (Order No. 86-1026); PUC 17-1987, f. & ef. 12-31-87 (Order No. 87-1309); PUC 5-1994, f. & cert. ef. 2-16-94 (Order No. 94-298); MCT 3-1996, f. & cert. ef. 3-14-96; Renumbered from 860-069-0005; MCT 4-1997, f. & cert. ef. 7-15-97; MCTD 5-2013, f. & cert. ef. 6-20-13

740-060-0020
Inventories

(1) An inventory of items will be prepared when requested by the shipper or when household goods are received into storage in transit or permanent storage.

(2) The carrier must list any damage or unusual wear.

(3) Shippers must be allowed to note in writing on the inventory documents any disagreement with entries regarding damage or unusual wear noted by the carrier.

Stat. Auth.: ORS 184.616, 184.619, 823.011 & 825.232
Stats. Implemented: ORS 825.202, 825.204, 825.224
Hist.: PUC 9-1986(Temp), f. & ef. 8-19-86 (Order No. 86-831); PUC 12-1986, f. & ef. 10-2-86 (Order No. 86-1026); MCT 3-1996, f. & cert. ef. 3-14-96; Renumbered from 860-069-0006; MCTD 5-2013, f. & cert. ef. 6-20-13

740-060-0035
Cargo Insurance and Valuation Declaration

(1) A carrier is liable for loss or damage to household goods when the property is in its care, custody or control. The required minimum level of cargo insurance coverage is specified in OAR 740-040-0030. The level of liability assumed by the carrier is altered based on the selection of the valuation protection option chosen by the shipper.

(2) Prior to beginning any regulated household goods move, a carrier must ensure that the shipper has selected a valuation option. The carrier must provide the shipper with information that clearly explains the different valuation options offered, the charges for each option, and an example comparing the total cost of a move with Full Replacement Cost Protection and with Released Value Protection.

(3) All household goods carriers must offer at least the following valuation protection options:

(a) Released Value: When the shipper elects the no-additional-cost Released Value option, claims for damage or loss will be settled based on the weight of the article multiplied by the price per pound. If a shipper fails to state a declared value in writing and the shipment is accepted by the carrier, the shipment will be estimated calculating the weight of the shipment as seven pounds per cubic foot of space utilized;

(b) Replacement Cost Protection: The shipper must declare a lump sum value of the shipment. Under this option, if any article is lost, destroyed, or damaged while in the carriers custody, the carrier will, at its option, guarantee either replacement of articles lost or damaged, reimbursement for full replacement cost, or satisfactory repairs.

(4) If for any reason, the carrier fails to obtain the shipper's written confirmation of valuation option selection on the bill of lading, and the shipment is accepted for transport, the carrier will provide Replacement Cost Protection at the shipper expense.

Stat. Auth.: ORS 184.616, 184.619, 823.011, 825.232
Stats. Implemented: ORS 825.202, 825.204, 825.224
Hist.: MCTD 5-2013, f. & cert. ef. 6-20-13

740-060-0040
Estimates of Charges

(1) Estimates must be prepared by the carrier when requested by the shipper. Estimate forms must be retained for three years with the freight bill for inspection by the Department's staff. Estimates must be:

(a) Free of charge;
(b) Provided in writing;
(c) Given only after visual inspection of household goods to be shipped;
(d) Non-binding; final charges must be based upon tariff rates filed with the Department; and
(e) Accompanied by an addendum when additional services are added and not included in the estimate. Addendum must be signed by the shipper.

(2) Underestimates for service. A carrier must not provide underestimates for service. An underestimate occurs when the charge assessed by the carrier exceeds the original estimate and addendum estimates for service by more than 10 percent.

(3) When full or partial payment is due upon delivery and the total tariff charges exceed estimated and addendum charges by more than 10 percent, a shipper may request deferment of the excess amount for 15 days. The shipper must pay the estimated charges plus 10 percent at the time of delivery. The carrier must relinquish possession of the shipment, when the estimated charges plus 10 percent is received. The 15-day extension does not include Saturdays, Sundays, and holidays as specified in the carrier's tariff.

Stat. Auth.: ORS 184.616, 184.619, 823.011 & 825.232
Stats. Implemented: ORS 825.202, 825.204 & 825.224
Hist.: PUC 156, f. 8-6-73, ef. 8-15-73 (Order No. 73-507); PUC 181, f. 12-30-77, ef. 1-15-78 (Order No. 77-896); Renumbered from 860-039-0010; PUC 9-1986(Temp), f. & ef. 8-19-86 (Order No. 86-831); PUC 12-1986, f. & ef. 10-2-86 (Order No. 86-1026); PUC 17-1987, f. & ef. 12-31-87 (Order No. 87-1309); MCT 2-1996, f. & cert. ef. 2-16-96; Renumbered from 860-069-0010; MCT 3-1996, f. & cert. ef. 3-14-96; MCT 4-1997, f. & cert. ef. 7-15-97; MCTD 2-2013(Temp), f. 1-17-13, cert. ef. 1-18-13 thru 7-15-13; MCTD 5-2013, f. & cert. ef. 6-20-13

740-060-0045
Criminal Background Checks

(1) Each carrier must obtain a criminal background check for each employee or any agent representing the carrier whose duties may require contact with the public or entry into a private residence or storage facility for the purpose of providing or facilitating the transportation of household goods. For the purpose of this rule:

(a) Carriers subject to these requirements are referred to as "Subject Employers."

(b) Employees or agents whose duties are described in this rule are referred to as "Subject Individuals."

(c) Criminal background checks must be completed prior to employment of Subject Individual and must be completed every three years.

(2) Criminal Background Check means a public record of court actions regarding the Subject Individual covering each state the Subject Individual has resided in the last five years.

(a) Subject Employers must require each Subject Individual, as a condition of employment, to sign a release authorizing the Subject Employer to obtain the criminal background check required by this rule;

(b) The Department may require Subject Employers to obtain additional criminal background information from law enforcement on Subject Individuals;

(c) Criminal background checks must include a list of offenses that the Subject Employee has been convicted in a court of law and the date of each conviction.

(3) Subject Employers must certify in their annual report due April 1 of each year that they are in compliance with all rules of the department and provide the following information about criminal history check activities:

(a) The number of Subject Individuals on whom criminal history checks were done during the preceding calendar year;

(b) The number of criminal history checks resulting in evidence of a criminal history including:

(A) Information about what was found without identifying the individual by name; and

(B) The Subject Employer's decision as to whether the Subject Individual was hired, or continued in employment, and if so, an explanation as to why.

(4) Subject Individuals may not perform duties which may require contact with the public or entry into a private residence or storage facility for the purpose of providing or facilitating the transportation of household goods if they have been convicted of any felony within the five years preceding the criminal background check. In addition to any felony conviction, Subject Individuals may not have been convicted of a misdemeanor involving:

(a) Theft;
(b) Burglary;
(c) Sexual conduct;
(d) Manufacture, sale or distribution of a controlled substance;
(e) Identity theft or
(f) False statements.

(5) Criminal background checks required by this rule must be retained by the carrier for at least three years from the date obtained.

Stat. Auth.: 184.616, 184.619, 823.011, 825.232
Stats. Implemented: 825.202, 825.204, 825.224, 825.325
Hist.: MCTD 2-2009, f. & cert. ef. 9-29-09; MCTD 5-2013, f. & cert. ef. 6-20-13

740-060-0055
Additional Fees

Each carrier must pay an annual fee of $100 or .1 percent of its gross revenue derived from Oregon intrastate household goods moving activity in the preceding year, whichever is greater. The fee is due by April 1 and must be reported on a form provided by the Department. A household goods carrier that fails to pay the fee required by the due date will be subject to suspension under ORS 825.139.

Stat. Auth.: ORS 184.616, 184.619, 823.011, 825.232
Stats. Implemented: ORS 825.139, 825.247
Hist.: MCTD 9-2003(Temp), f. 12-12-03, cert. ef. 1-1-04 thru 6-28-04; MCTD 3-2004, f. 6-24-04, cert. ef. 6-29-04; MCTD 5-2013, f. & cert. ef. 6-20-13

740-060-0060
Signed Receipt for Shipment — Release Prohibited

Shipping documents or other records signed by the shipper to acknowledge delivery must not include language that releases or discharges the carrier from liability. A statement that the property has been received in apparent good condition except as noted may be included on the shipping documents.

Stat. Auth.: ORS 184.616, 184.619, 823.011, 825.232
Stats. Implemented: ORS 823.101, 825.224
Hist.: PUC 156, f. 8-6-73, ef. 8-15-73 (Order No. 73-507); Renumbered from 860-039-0020; MCT 3-1996, f. & cert. ef. 3-14-96; Renumbered from 860-069-0020; MCTD 5-2013, f. & cert. ef. 6-20-13

740-060-0070
Claims for Loss or Damage

(1) For a shipper to be compensated for loss or damage, a written claim must be filed with the carrier or carrier's agent within three months of the date of delivery.

(2) Acknowledgment of claims. Written claims for loss or damage to household goods must be acknowledged by the carrier in writing within 30 calendar days of the receipt of the claim. The carrier must record the date and time the claim was received.

(3) Handling by carrier. A carrier must pay, decline, or make a firm compromise settlement offer in writing to the shipper within 120 days from the date the claim was received. If the claim is not be resolved within 120 days from the date the claim was received, the carrier must inform the shipper and the Department of the reason in writing. Written communication with the shipper and the Department of reasons why the claim is not resolved must be provided each succeeding 60-day period while the claim remains unresolved.

(4) Register of loss and damage claims. Every carrier must maintain a freight claim register. The claim register must show each cargo loss and damage claim received, the claim number, date, and amount; the waybill or expense bill number and date; name of claimant; kind of commodity; date claim was paid; total amount paid; or date claim was disallowed and reasons; amount of salvage recovered, if any; amounts reimbursed by insurance companies, connecting carriers, or others, and the amount absorbed by the carriers. Claim registers and supporting documentation must be retained for three years.

Stat. Auth.: ORS 184.616, 184.619, 823.011, 825.232
Stats. Implemented: ORS 823.101, 823.103, 825.202
Hist.: PUC 156, f. 8-6-73, ef. 8-15-73 (Order No. 73-507); Renumbered from 860-039-0030; MCT 2-1996, f. & cert. ef. 2-16-96; Renumbered from 860-069-0030; MCT 3-1996, f. & cert. ef. 3-14-96; MCTD 5-2013, f. & cert. ef. 6-20-13

740-060-0080
Determination of Weight for Weight Distance Moves

(1)(a) A carrier subject to rates based on weight must determine the gross weight, tare weight and net weight or constructive weight of a shipment. A carrier transporting shipments of household goods subject to rates based on the weight of shipment must determine the tare weight of each vehicle used by having it weighed prior to the transportation of each shipment, with the driver for the proposed trip but without the crew. The weight must be determined by a certified weighmaster or on a certified scale, and the fuel tanks on the vehicle must be full and the vehicle must contain all pads, chains, dollies, hand trucks, and other equipment needed in the transportation of shipments to be loaded, and the weight must then be entered on the bill of lading. After the vehicle has been loaded, it must be weighed, with the same driver and equipment but without the crew, at the certified scale nearest to the point of origin of the shipment, and the net weight of the shipment must be obtained by deducting the tare weight from the gross weight, and both the gross and net weights must be entered on the bill of lading. Where no certified scale is available at the point of origin, the gross weight must be obtained at the nearest certified scale either in the direction of the movement of the shipment, or in the direction of the next pickup or delivery in the case of part loads. In the transportation of part loads, this rule must apply in all respects, except that the gross weight of a vehicle containing one or more part loads must be used as the tare weight of such vehicle as to part loads subsequently loaded. Also, the person paying the freight charges, or his representative, at the request of either, must be per-

mitted, without charge, to accompany the carrier to the weighing station in his own vehicle and to observe the weighing of his shipment after loading. The carrier must use a certified scale which will permit the shipper to observe the weighing of his shipment without causing delay; or

(b) If no certified scale is available at origin at any point en route or at destination, a constructive weight, based upon 7 pounds per cubic foot of properly loaded van space, may be used, provided the shipper is notified prior to unloading that this method will be used to determine weight and charges on the shipment.

(2) Obtaining weight tickets. The carrier must obtain a weight ticket signed by the weighmaster for each weighing required under this rule, with tare and gross weights evidenced by separate tickets, and the driver must enter the number of the bill of lading accompanying the shipment involved. No other additions or alterations will be made on the ticket. True copies must be attached to the receipt or bill of lading accompanying the shipment, and retained in the carrier's file for three years. A true copy of each weight ticket pertaining to a shipment must be given to the shipper at the weighing station if the shipper is present or at delivery of the shipment if the shipper is not present at the weighing. A part load for any one shipper not exceeding 1,000 pounds may be weighed on a certified scale prior to being loaded on the vehicle. Additionally, an automobile or other article weighing in excess of 500 pounds which is mounted on wheels may be weighed separately by obtaining the weight of such article on a certified scale prior to loading on the vehicle to be used in its transportation.

(3) Minimum weight shipments. Before accepting a shipment of household goods for transportation which appears to be subject to the minimum weight provisions of the carrier's tariff, the carrier must advise the shipper of the minimum weight provisions.

(4) Reweighing of shipment. The carrier must reweigh the shipment, if the shipper requests a reweigh prior to the delivery date of the shipment. The carrier must inform the shipper, within a reasonable time prior to the gross reweighing, of the tariff charges and the location of a certified scale which will be used. The carrier, without altering or deleting the initial weights, will write on the bill of lading the gross, tare and net weights on reweigh, and must give the shipper, or his representative, original or true copies of the weight tickets on reweigh in the same manner as prescribed for initial weighing. The lower of the two net scale weights must be used for determining the applicable charges. Charges for reweighing will be determined by tariff rates.

Stat. Auth.: ORS 184.616, 184.619, 823.011 & 825.232
Stats. Implemented: ORS 825.202
Hist.: PUC 156, f. 8-6-73, ef. 8-15-73 (Order No. 73-507); Renumbered from 860-039-0040; MCT 2-1996, f. & cert. ef. 2-16-96; Renumbered from 860-069-0040; MCT 3-1996, f. & cert. ef. 3-14-96; MCTD 2-2013(Temp), f. 1-17-13, cert. ef. 1-18-13 thru 7-15-13; MCTD 5-2013, f. & cert. ef. 6-20-13

740-060-0085
Hourly Rate Local Moves

A carrier must apply a local hourly rate when a move is wholly within a city limit or commercial zone specified in the carrier's ODOT approved local cartage authority. The Department may approve an extension to the radius of mileage for a commercial zone when approving a tariff.

Stat. Auth.: ORS 184.616, 184.619, 823.011, 825.232
Stats. Implemented: ORS 825.202
Hist.: MCTD 5-2013, f. & cert. ef. 6-20-13

740-060-0090
Hourly Rate Distance Moves

If a carrier elects to provide an hourly distance rate, as specified in its tariff, the hourly rate charged for the transit time to and from the move locations are limited to the following;

(1) The calculation of time it takes for a carrier to travel from the terminal location to the origin of the move must be determined by Google Map miles or a truck routing and mileage software program using the address to address locations to establish the estimated time of travel to be charged to the shipper.

(2) The return trip from the destination of the move to the terminal location must be determined by Google Map miles or a truck routing and mileage software program using the address to address locations to establish the estimated time of travel to be charged to the shipper.

Stat. Auth.: ORS 184.616, 184.619, 823.011, 825.232
Stats. Implemented: ORS 825.202
Hit.: MCTD 5-2013, f. & cert. ef. 6-20-13

740-060-0100
Cartage Areas Exempt from Economic Regulation

Carriers engaged in the transportation of household goods moving wholly within the incorporated city limits of each of the cities as set out in Exhibit 1 are exempt from regulations, pursuant to ORS 825.240. A carrier that performs local cartage moves within the cities specified in Exhibit 1 must obtain a permit in accordance with ORS 825.127.

[ED. NOTE: Exhibits referenced are available from the agency
Stat. Auth.: ORS 184.616, 184.619, 823.011, 825.232
Stats. Implemented: ORS 825.127, 825.240
Hist.: PUC 5-1978, f. & ef. 12-20-78 (Order No. 78-924); Renumbered from 860-039-0050; PUC 1-1983, f. & ef. 1-17-83 (Order No. 83-024); MCT 2-1996, f. & cert. ef. 2-16-96; Renumbered from 860-069-0050; MCT 3-1996, f. & cert. ef. 3-14-96; MCTD 2-2009, f. & cert. ef. 9-29-09; MCTD 5-2013, f. & cert. ef. 6-20-13

740-060-0110
Commercial Zones

(1) The territorial limits of the commercial zone of each designated city includes the following areas:

(a) Astoria, Oregon includes all points located within the incorporated city limits of Astoria, Hammond, and Warrenton and within one (1) airmile distance of their combined city limits;

(b) Coos Bay, Oregon includes all points located within the incorporated city limits of Coos Bay, Eastside, and North Bend and within one (1) airmile distance of their combined city limits;

(c) Eugene, Oregon includes all points located within the incorporated city limits of Eugene and Springfield, Oregon, and within a three (3) airmile distance of their combined city limits;

(d) Klamath Falls, Oregon includes all points located within the incorporated city limits of Klamath Falls, Oregon, and within four (4) airmile distance of the city limits;

(e) Medford, Oregon includes all points located within the incorporated city limits of Central Point, Jacksonville, Medford, Phoenix, and the unincorporated community of White City. The Medford Commercial Zone also includes other points located and within an eight (8) airmile radius of the intersection of I-5 and Crater Lake Highway (OSH 62);

(f) Salem, Oregon includes all points located within the incorporated city limits of Salem and Keizer. The Salem Commercial Zone also includes other points within a three (3) airmile distance of the city limits of Salem;

(g) Portland, Oregon includes all points located within the incorporated city limits of Portland, Oregon, and within a ten (10) airmile distance of said city limits; and includes all of the area located within the incorporated limits of any city any part of which is located within a ten (10) airmile distance of the city limits of Portland.

(2) Local Cartage operating authority of household goods carriers at any city located within a commercial zone as defined in subsections (1)(a) to (g) of this rule includes transportation of household goods between all points located within the territorial limits of the Commercial Zone.

Stat. Auth.: ORS 184.616, 184.619, 823.011, 825.232
Stats. Implemented: ORS 825.234, 825.240
Hist.: PUC 5-1978, f. & ef. 12-20-78 (Order No. 78-924); PUC 2-1980, f. & ef. 3-27-80 (Order No. 80-179); PUC 7-1980, f. & ef. 11-6-80 (Order No. 80-845); Renumbered from 860-039-0060; PUC 16-1983, f. & ef. 12-28-83 (Order No. 83-863); MCT 2-1996, f. & cert. ef. 2-16-96; Renumbered from 860-069-0060; MCT 3-1996, f. & cert. ef. 3-14-96; MCTD 5-2013, f. & cert. ef. 6-20-13

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Department of Veterans' Affairs
Chapter 274

Rule Caption: Relating to the definition of "Under Honorable Conditions" and "Honorably Discharged"
Adm. Order No.: DVA 2-2013
Filed with Sec. of State: 7-8-2013
Certified to be Effective: 7-8-13
Notice Publication Date: 6-1-2013
Rules Amended: 274-010-0100, 274-012-0001, 274-020-0200, 274-045-0001
Subject: The 77th Oregon Legislative Assembly - 2013 Regular Session passed House Bill 2633 which added the definition of "Honorable Conditions" to ORS 408.225. HB 2633 also amended ORS 407.090 to have the Department of Veterans' Affairs adopt the meaning of "Honorable Conditions" into rule. For clarification and consistency, the term "Honorably Discharged" has the same meaning as "Honorable Conditions."
Rules Coordinator: Nicole Hoeft—(503) 373-2386

274-010-0100
Definitions for 274-010-0100 to 274-010-0175

As used in these regulations or any amendments to them, or in any blank form, document, publication, or written instrument of any kind prescribed, provided, published, issued, or used by the Director or any of his

duly authorized agents or employees in connection with the administration of the provisions of ORS 408.010 to 408.110, unless otherwise required by context:

(1) "Active Duty" or "Active Service" means that status in the Armed Forces in which the person on "active duty" is under the command of military or naval authorities, subject to military or naval discipline and on active duty pay status in the respective arm or branch of the Armed Forces in which the person is serving.

(a) Members of the reserve components of the Armed Forces, persons on a retired status in the military or naval forces of the United States, Cadets at West Point, Air Force Academy, and United States Coast Guard Academy and Midshipmen at the Naval Academy were on active duty only after reporting for active duty;

(b) Members of the National Guard were on active duty only after having been activated under Title 10 of the United States Code of Federal Regulations;

(2) "Armed Forces" means and includes:

(a) Army;

(b) Navy;

(c) Marines;

(d) Air Force;

(e) Coast Guard;

(f) Coast and Geodetic Survey (while serving with Army or Navy);

(g) Commissioned Officers of Public Health Service while serving with Army, Navy, Marine Corps, or Coast Guard.

(3) "Beneficiary" means any person eligible for educational aid as defined in ORS 408.010.

(4) "Veteran" means any person who served on active duty with the Armed Forces of the United States as defined in ORS 408.225.

(5) "Under Honorable Conditions" means that the official documents of discharge, service, or separation issued upon the termination of the veteran's active duty service with the Armed Forces are characterized as one of the following:

(a) "Honorable"; or

(b) "General" also known as "General Under Honorable Conditions".

(6) "Alien" means any person who is not a citizen of the United States.

(7) "Alien Enemy" means any person who is a citizen of any nation, country, or state, or ally thereof, with which the United States is at war.

(8) "Conscientious Objector" means any person who during his period of service refused on conscientious, political, or other grounds to subject himself to full military discipline and unqualified service.

(9) "Combat Zone" means any area designated by the President of the United States by executive order in which the Armed Forces of the United States or any subdivision thereof are or have engaged in combat.

(10) "Other Like Training Program" means college training while in service, which compares with the civilian professional training for which college credit was, or could be, obtained to apply toward graduation from an approved institution of higher learning.

(11) "Domicile" or "Residence" means that place which a person intends as their fixed place of abode or habitation; which they consider to be their permanent home; and to which, whenever away, they always intend to return:

(a) Temporary absence from the state does not destroy domicile;

(b) Temporary presence in the state without an intention to establish a permanent home does not support a contention of being domiciled within the state.

(12) "Accredited Institution" means any institution where training is offered that has been certified as meeting the minimum requirements prescribed by the accrediting agency having jurisdiction over standards of uniformity and accreditation (the State Department of Education).

(13) "Approved Course of Study or Vocational Training" means any course of training outlined in the material submitted to and approved by the State Department of Education.

(14) "Full Time College Course" means that the particular course has met the following standards:

(a) "Full time" — As defined by the approved institution where the course is being pursued;

(b) "College" — An institution fully accredited by the appropriate accrediting agency, as recognized by the State Approving Agency (the State Department of Education).

(15) "Current Term" means:

(a) Fall, winter, spring, or summer term in those institutions operating on a term or quarter basis;

(b) First or second semester or summer session in those institutions operating on a semester or half year basis; or

(c) Not later than six weeks following enrollment in a training institution where training is a continuous program, not divided into terms or semesters.

(16) "Executive Head of the Institution" means:

(a) The President of the University or College;

(b) The Principal of the School;

(c) The Director of the Training establishment; or

(d) The person or persons to whom the executive head of the institution has delegated authority to act in his stead.

Stat. Auth.: ORS 408, 2013 HB 2633
Stats. Implemented: ORS 408.010–408.090, 2013 HB 2633
Hist.: DVA 22, f. 11-15-57, ef. 11-14-57; DVA 32, f. 12-2-65, ef. 12-25-65; DVA 9-1993, f. 9-13-93, cert. ef. 11-4-93; DVA 1-2006, f. & cert. ef. 1-27-06; DVA 3-2007, f. & cert .ef. 9-25-07; DVA 2-2013, f. & cert. ef. 7-8-13

274-012-0001
Definitions for OAR 274-012-0001 through 274-012-0131

As used in Sections 0001 through 0131 of division 012, unless otherwise required by context:

(1) "Department" or "ODVA" means the State of Oregon Department of Veterans' Affairs.

(2) "Program" or "OVEFAP" means the Oregon Veterans' Emergency Financial Assistance Program as established in ORS 408.500.

(3) "Under Honorable Conditions" means that the official documents of discharge, service, or separation issued upon the termination of the veteran's active duty service with the Armed Forces are characterized by the relevant branch of the Armed Forces as one of the following:

(a) "Honorable"; or

(b) "General" also known as "General Under Honorable Conditions".

(4) "Veteran" means a veteran as defined in ORS 408.500.

(5) "Immediate family" means a spouse, child or stepchild.

Stat. Auth.: ORS 406.030, 406.050, 406.130, 408.010, 408.225, 408.500, 2013 HB 2633
Stats. Implemented: 2013 HB 2633
Hist.: DVA 2-2006(Temp), f. & cert. ef. 2-23-06 thru 8-18-06; DVA 4-2006, f. & cert. ef. 4-25-06; DVA 1-2008(Temp), f. & cert. ef. 1-7-08 thru 6-30-08; DVA 3-2008, f. & cert. ef. 2-22-08; DVA 2-2013, f. & cert. ef. 7-8-13

274-020-0200
Definitions for OAR 274-020-0200 to 274-020-0450

As used in these regulations or any amendments to them, or any blank form, document, publication, or written instrument of any kind prescribed, provided, published, issued, or used by the director or any of his duly authorized agents or employees in connection with the administration of the provisions of Article XI A of the Oregon Constitution and ORS Chapter 407, providing for the loaning of money to qualified persons who served in the Armed Forces of the United States, unless otherwise required by context:

(1) "Armed Forces" means and includes:

(a) Army;

(b) Navy;

(c) Marines;

(d) Air Force;

(e) Coast Guard;

(f) WAC (Since July 1, 1943);

(g) Waves;

(h) Women Marines;

(i) WAFS;

(j) Spars;

(k) Women's Air Force Service Pilots (WASP);

(l) Commissioned Officers of the Public Health Service. Service with Coast Guard between December 23, 1941, and November 10, 1943, inclusive. Service with the Army, Navy, Marine Corps, or Coast Guard between November 11, 1943, and July 28, 1945, inclusive. Eligible by executive order between July 29, 1945, and July 3, 1952, inclusive. Since July 3, 1952, when serving with the Armed Forces;

(m) Active service of commissioned officers of the National Oceanic and Atmospheric Administration or its predecessor organization, the Coast and Geodetic Survey, after July 29, 1945. Coast and Geodetic Survey officers while serving with the Army or Navy before July 29, 1945.

(2) "Active Duty" means that status in the Armed Forces in which the person on "active duty" is under the command of and subject to discipline and on active duty pay status in the respective branch of the Armed Forces in which the person is serving:

(a) Members of the reserve components; persons on a retired status from the Armed Forces; cadets at West Point, the United States Coast

Guard Academy, the United States Air Force Academy, and Midshipmen at Annapolis, were on active duty only after reporting for active duty;

(b) Members of the National Guard were on active duty only after having entered active Federal Service for duty other than training.

(3) "Honorably Discharged" means that the official documents of discharge, service, or separation issued upon the termination of the veteran's service with the Armed Forces are characterized as:

(a) "Honorable"; or

(b) "General" also known as "General Under Honorable Conditions".

(4) "Separated" means the termination of active duty with the Armed Forces.

(5) "Resident" or "Bona Fide Resident" means one who has domiciled within the state.

(6) "Domicile" means the legal residence of a veteran and consists of actual or inchoate residence in conjunction with the intention to maintain that residence, or the home of the veteran, where, when temporarily away, he has the intention of returning:

(a) Temporary absence from the state, such as vacation, military leave, or reasons of health, will not destroy the domicile;

(b) Temporary presence in the state without an intention to establish a permanent home will not support a domicile in the state;

(c) Domicile of an unemancipated minor shall be governed by his legal parent, (if the parents are divorced, the one having custody controls);

(d) Domicile of an emancipated minor shall be determined by choice.

(7) "Acquisition" means:

(a) The purchase and improvement of a home or farm; or

(b) The payment of the balance of a purchase price and interest on purchase contract of a home or farm and its improvements; or

(c) The refinancing of an existing purchase money security instrument on a home or farm or an instrument in the nature thereof, and the improvement of the property purchased; or

(d) Improvements of a home or farm.

(8) "Improvements" means any new construction, or any necessary or beneficial additions, alterations, or changes appurtenant to the house which add to the appraised value of the premises.

(9) "Security" means all of the real property, mobile home, or floating home that is to be acquired for a home and for which purpose the loan is requested.

(10) "Home" means any residential type structure, including outbuildings and the real property in connection with it, if any, including long term leaseholds, which is established, maintained, and used primarily as a principal residence by the veteran.

(11) "Farm" includes:

(a) "Home"; and

(b) A parcel of land being used to obtain a profit in money by utilizing accepted farming practices to raise crops or livestock or poultry or dairying or combinations thereof.

(12) "Security Instrument" means a mortgage, deed of trust, or similar document used to perfect the lien on the security by the Director of Veterans' Affairs (ODVA). The lien will be a first lien on the home, except:

(a) As otherwise required by Oregon law, or allowed by Oregon law and approved in writing by ODVA; or

(b) When an ALTA mortgagee's title insurance policy is in force insuring the state against the usual losses covered by an ALTA policy as well as any loss from any prior encumbrance, and the encumbrance is acceptable to both the veteran and ODVA.

(13) "Minor" means any single person under the age of 18 years, but any person shall be deemed to have arrived at the age of majority upon their marriage.

(14) "Transfer" means a change of ownership, either by operation of law, act of the parties, or both, such as deed, contract, certificate, court decree, property settlement, foreclosure, easement, condemnation, or adverse possession of the premises.

(15) "Lease" means the giving of possession and use of profits of secured property for a period of time in return for compensation.

(16) "Possession" means exclusive dominion and physical control of the secured property but occupancy is not necessary.

(17) "Lease Option" means a lease of real property with an option to purchase the property within a stipulated period of time.

(18) "Rent" means the giving of possession of secured property for occupancy for a specific period of time in return for a stipulated amount of compensation.

(19) "Underwriter/Designated Loan Officers" means those employees of the Department whose paramount responsibility shall be the approval or rejection of all applications for loans.

(20) "Department" means the Oregon Department of Veterans' Affairs (ODVA).

(21) "Net Appraised Value" is also known as loan value," and both terms mean the lesser of the appraised value or the Purchase Price. The "appraised value" is the value established by an appraisal obtained by or at the direction of ODVA, or an appraisal approved by ODVA.

(22) "Loan to Value Ratio" is the loan amount or balance divided by the net appraised value.

(23) "Original Loan" means:

(a) The first loan the veteran receives; or

(b) The first loan based on a restored loan right.

(24) "Subsequent Loan" means any loan or loans granted after the original loan and are in these categories:

(a) Additional loan;

(b) Second loan; and

(c) Veterans' Home Improvement loan.

(25) "Veteran" means any person eligible to receive a loan under the provisions of Article XI A of the Oregon Constitution and sections (1) through (6) of this rule.

Stat. Auth.: ORS 406.030, 407.115 & 2013 HB 2633

Stats. Implemented: ORS 407, 2013 HB 2633

Hist.: DVA 22, f. 11-15-57, ef. 11-14-57; DVA 26, f. 12-13-60; DVA 29, f. 7-3-63, ef. 9-2-63; DVA 32, f. 12-2-65, ef. 10-25-65; DVA 33, f. 12-7-66, ef. 1-11-67; DVA 35, f. 12-19-68, ef. 1-11-69; DVA 38, f. 5-10-71, ef. 6-11-71; DVA 43, f. 3-2-73, ef. 3-29-73; DVA 45, f. & ef. 12-1-75; DVA 47, f. & ef. 4-20-76; DVA 48, f. & ef. 1-3-77; DVA 50, f. 11-16-77, ef. 12-1-77; DVA 1-1980, f. & ef. 1-15-80; DVA 4-1980, f. & ef. 12-1-80; DVA 3-1990, f. & cert. ef. 5-1-90; DVA 10-1995, f. 9-11-95, cert. ef. 9-22-95; DVA 12-1995, f. & cert. ef. 9-22-95; DVA 5-1997, f. & cert. ef. 10-22-97; DVA 2-2005, f. & cert. ef. 4-22-05; DVA 2-2013, f. & cert. ef. 7-8-13

274-045-0001

Definitions for OAR 274-045-0001 to 274-045-0480

As used in these regulations or any amendments to them, or any blank form, document, publication, or written instrument of any kind prescribed, provided, published, issued, or used by the director or any of his duly authorized agents or employees in connection with the administration of the provisions of Article XI-A of the Oregon Constitution and ORS Chapter 407, providing for the loaning of money to qualified persons who served in the Armed Forces of the United States, unless otherwise required by context:

(1) "Armed Forces" means and includes:

(a) Army;

(b) Navy;

(c) Marines;

(d) Air Force;

(e) Coast Guard;

(f) National Guard;

(g) Federal Reserve Forces;

(2) "Active Duty" means that status in the Armed Forces in which the person on "active duty" is under the command of and subject to discipline and on active duty pay status in the respective branch of the Armed Forces in which the person is serving:

(a) Members of the reserve components; persons on a retired status from the Armed Forces; cadets at the United States Military Academy, and the United States Air Force Academy, and Midshipmen at the United States Naval Academy and the United States Coast Guard Academy, were on active duty only after reporting for active duty;

(b) Members of the National Guard were on active duty only after having entered active Federal Service for duty other than training.

(3) "Acquisition" means:

(a) The purchase and improvement of a home; or

(b) The payment of the balance of a purchase price and interest on purchase contract of a home and its improvements; or

(c) The refinancing of an existing purchase money security instrument on a home or an instrument in the nature thereof, and the improvement of the property purchased; or

(d) Improvements of a home.

(4) "Agreement" means the contract between the Oregon Department of Veterans' Affairs (ODVA) and the approved lender, setting forth the terms and conditions under which program loans made by the approved lender will be purchased by the ODVA.

(5) "ALTA Mortgagee's Title Insurance" means a title insurance policy issued in American Land Title Insurance form by a title insurer licensed by the State of Oregon.

(6) "Approved Lender" means any "Lending Institution" as defined in ORS 407.177(8) that has entered into an agreement with ODVA to originate residential loans acceptable to ODVA or to act as a conduit for the origination of residential loans acceptable to ODVA. In determining whether or

not to contract with a Lending Institution, ODVA may consider factors including, but not limited to the following:

(a) ODVA's need for additional Approved Lenders, either on a statewide basis or in a specific geographical area,

(b) Whether or not the Lending Institution has had any complaints filed against it or against any of its employees, agents, officers, directors, owners, or affiliates through the Consumer and Business Services Department of the State of Oregon, through any other regulatory agency or otherwise.

(c) Whether or not representatives of the Lending Institution have attended any ODVA-sponsored training.

(d) The reputation of the Lending Institution, including its employees, agents, officers, directors, owners or affiliates.

(e) The number and experience of Lending Institution employees and other personnel available to originate loans or to act as a conduit for the origination of residential loans acceptable to ODVA.

(f) Status and character of the institution's loan policies and procedures.

(g) The financial capability of the Lending Institution to originate loans or to act as a conduit for the origination of loans.

(h) The Lending Institution's qualification as a loan originator or a seller/servicer for the Federal National Mortgage Association, the Federal Home Loan Mortgage Association, or the United States Department of Veterans' Affairs.

(i) Whether or not the deposits of the Lending Institution are insured by FDIC or some other federal agency or corporation.

(j) The experience, efficiency and performance of the Lending Institution in the area of residential lending and any other area of the Lending Institution's business.

(k) The willingness and commitment of the Lending Institution to accept and to fulfill the terms of an ODVA proposed contract.

(l) The result of any references which are checked as part of the application process.

(7) "Commitment" means a promise made by the ODVA to an Approved Lender or veteran, evidenced by a written commitment letter, setting forth the terms upon which the ODVA will purchase, originate, or accept by underwriting and closing a specific program loan made or processed by the Approved Lender or ODVA pursuant to a reservation of funds.

(8) "Department" means the Oregon Department of Veterans' Affairs.

(9) "Director" means the Director of Veterans' Affairs for the State of Oregon.

(10) "Domicile" means the legal residence of a veteran and consists of actual or inchoate residence in conjunction with the intention to maintain that residence, or the home of the veteran, where, when temporarily away, he or she has the intention of returning:

(a) Temporary absence from the State, such as vacation, military leave, or reasons of health, will not destroy the domicile;

(b) Temporary presence in the State without an intention to establish a permanent home will not support a domicile in the State;

(c) Domicile of an unemancipated minor shall be governed by his legal parent, (if the parents are divorced, the one having custody controls);

(d) Domicile of an emancipated minor shall be determined by choice.

(11) "Home" means any house or dwelling, including outbuildings, and the real property in connection with it, where the veteran has, or will, establish domicile.

(12) "Honorably Discharged" means that the official documents of discharge, service, or separation issued upon the termination of the veteran's service with the Armed Forces are characterized as one of the following:

(a) "Honorable"; or

(b) "General" also known as "General Under Honorable Conditions".

(13) "Improvements" means any new construction, or any necessary or beneficial additions, alterations, or changes appurtenant to the house, which add to the appraised value of the premises.

(14) "Lease" means the giving of possession and use of profits of secured property for a period of time in return for compensation.

(15) "Lease Option" means a lease of real property with an option to purchase the property within a stipulated period of time.

(16) "Lending Institution" means an entity which is licensed, or otherwise legally authorized, to conduct business in the State of Oregon exclusively or in part as a mortgage lender or a conduit for mortgage loans and that, in the judgment of ODVA, is capable of meeting the needs of ODVA in carrying out the purposes of ORS Chapter 407. In determining whether or not an entity that is licensed, or otherwise legally authorized, to conduct business in Oregon exclusively or in part as a mortgage lender or a conduit for mortgage loans is capable of meeting the needs of ODVA in carrying out the purposes of ORS Chapter 407, ODVA may consider factors including, but not limited to the following:

(a) Whether or not the entity qualifies as a "Banking Institution" or similar entity including, but, not limited to an "Extranational Institution," a "Federal Bank," a "Federal Savings Bank," or a "Financial Institution" under ORS 706.005, 706.008, 707.744, or 723.042.

(b) Whether or not the entity qualifies as a "mortgage broker" under ORS 59.840 through 59.965 for a period of three years.

(c) Whether or not the representatives of the entity have attended any ODVA-sponsored training.

(d) The reputation of the entity or of any of its employees, agents, officers, directors, affiliates or owners.

(e) The financial capability of the entity to originate loans or to act as a conduit for the origination of loans.

(f) The entity's qualification as a loan originator or a seller/servicer for the Federal National Mortgage Association, the Federal Home Loan Mortgage Association, or the United States Department of Veterans Affairs.

(g) The experience, efficiency, and performance of the entity in the areas of residential lending and any other area of the entity's business.

(17) "Loan Origination Guide/Mortgage Loan Origination Guide" means the manual containing the origination instructions for the Post Vietnam Era Veterans' Home Loan Program, and any subsequent changes as they are effected.

(18) "Loan to Value Ratio" is the loan amount or balance divided by the net appraised value.

(19) "Minor" means any single person under the age of 18 years, but any person shall be deemed to have arrived at the age of majority upon their marriage.

(20) "Net Appraised Value" is also known as "loan value," and both terms mean the lesser of the appraised value or the purchase price. The "appraised value" is the value established by an appraisal obtained by or at the direction of ODVA, or an appraisal approved by ODVA.

(21) "ODVA" means the Oregon Department of Veterans' Affairs acting by and through the director as defined in ORS 407.085(2)(b).

(22) "Original Loan" means:

(a) The first loan the veteran receives; or

(b) The first loan based on a restored loan right.

(23) "Possession" means exclusive dominion and physical control of the secured property but occupancy is not necessary.

(24) "Post Vietnam Era Veterans' Home Loan Program " means all home loans originated under this Division.

(25) "Qualified Insurer" means private mortgage insurance company(ies) licensed to do business in Oregon and with which ODVA has agreed to accept mortgage insurance coverage.

(a) When an ALTA mortgagee's title insurance policy is in force insuring the State against the usual losses covered by an ALTA policy as well as any loss from any prior encumbrance, and the encumbrance is acceptable to both the veteran and ODVA.

(26) "Rent" means the giving of possession of secured property for occupancy for a specific period of time in return for a stipulated amount of compensation.

(27) "Reservation of Funds" (Rate Lock) means the setting aside of specific funds at a designated interest rate for a specific period of time.

(28) "Resident" or "Bona Fide Resident" means one who has domiciled within the State.

(29) "Security" means all of the real property that is to be acquired for a home and for which purpose the program loan is requested.

(30) "Security Instrument" means a mortgage, deed of trust, or similar document used to perfect the lien on the security by the ODVA. The lien will be a first lien on the home, except:

(a) As otherwise required by Oregon law, or allowed by Oregon law and approved in writing by ODVA; or

(b) When an ALTA mortgagee's title insurance policy is in force insuring the State against the usual losses covered by an ALTA policy as well as any loss from any prior encumbrance, and the encumbrance is acceptable to both the veteran and ODVA.

(31) "Separated" means the termination of active duty with the Armed Forces.

(32) "Subsequent Loan" means any loan or loans granted after the original loan and are in these categories:

(a) Additional loan;

(b) Second loan; and

(c) Veterans' Home Improvement loan.

(33) "Transfer" means a change of ownership, either by operation of law, act of the parties, or both, such as deed, contract, certificate, court decree, property settlement, foreclosure, easement, condemnation, or adverse possession of the premises.

(34) "Underwriter/Designated Loan Officers" means those employees of ODVA whose paramount responsibility shall be the approval or rejection of all applications for loans.

(35) "Veteran" means any eligible veteran as described in OAR 274-045-0001 through 274 045 0001(2)(b) eligible to receive a loan under the provisions of Article XI-A of the Oregon Constitution.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 406.030 & 407.115, OR Leg. Assembly, 2013, Ch. 16 (HB 2633)

Stats. Implemented: ORS Chapter 407, OR Leg. Assembly, 2013, Ch. 16 (HB 2633)

Hist.: DVA 2-2001, f. & cert. ef. 5-23-01; DVA 3-2001(Temp), f. & cert. ef. 6-15-01 thru 12-11-01; DVA 9-2001, f. & cert. ef. 11-23-01; DVA 2-2005, f. & cert. ef. 4-22-05; DVA 3-2007, f. & cert .ef. 9-25-07; DVA 2-2013, f. & cert. ef. 7-8-13

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Rule Caption: Relating to fees that may be charged for ordinary Conservator services
Adm. Order No.: DVA 3-2013(Temp)
Filed with Sec. of State: 7-9-2013
Certified to be Effective: 7-9-13 thru 1-3-14
Notice Publication Date:
Rules Amended: 274-015-0010
Subject: The 77th Oregon Legislative Assembly — 2013 Regular Session passed House Bill 2044 which allows the Oregon Department of Veterans Affairs, when appointed as a conservator, to set forth by rule reasonable compensation for ordinary and unusual services. Allows Department to charge up to 10% of income to the estate for ordinary services.
Rules Coordinator: Nicole Hoeft—(503) 373-2386

274-015-0010
Conservatorship Fees

(1) The Director of Veterans' Affairs (DVA) may charge fees when acting as the Conservator of the estate of a protected person. The fees DVA may charge are as follows:

(a) For ordinary services, up to 10% of income to the estate;

(b) For unusual services:

(A) $40 per hour for real property management;

(B) $ Real property appraisal, actual cost;

(C) $ 50 per real property inspection.

(2) The sources of income upon which DVA will impose a fee are as follows:

(a) VA Compensation;

(b) VA Pension;

(c) VA Accumulated Benefits;

(d) VA Death Indemnity Compensation (DIC);

(e) VA Death Pension (Spouse, Child);

(f) VA Education;

(g) VA Rehabilitation;

(h) Social Security;

(i) State Retirement;

(j) Federal Civil Service Retirement (CSA);

(k) Worker's Compensation;

(l) Railroad Retirement;

(m) Union Pension;

(n) Life Insurance Annuity;

(o) Private Disability Insurance;

(p) Military Retirement;

(q) Wages;

(r) Interest income earned through investments made by the State Treasurer.

(3) As used in applicable Oregon Law and this rule, unless otherwise required by context:

(a) "Ordinary services" means services performed routinely for or on behalf of protected persons for whom DVA acts as Conservator;

(b) "Unusual services" means services provided to protected persons that go beyond being ordinary or routine services. "Unusual services" include, but are not limited to, management of real property, real property appraisals, and real property inspections.

(4) In deciding whether all or a portion of the fees will be waived, the Director shall consider the following:

(a) Whether the protected person has at least $2,000 in cash and investment assets;

(b) Whether, after payment of a fee, the protected person would have sufficient funds to pay all outstanding bills, and have money remaining to pay for such basic needs as food, shelter, clothing, and medical care;

(c) Whether the protected person receives public assistance;

(d) Whether all foreseeable expenses have been taken into account in deciding what the needs of the protected person will be.

Stat. Auth.: ORS 113.085, 406.030, 406.040, 406.050(5), 406.050(6) & 406.100

Stats. Implemented: ORS 406.050, 406.100, 406.110 & 406.120

Hist.: DVA 9-1987, f. 11-25-87, ef. 12-1-87; DVA 4-1991, f. & cert. ef. 7-1-91; DVA 1-2012, f. & cert. ef. 2-22-12; DVA 3-2013(Temp), f. & cert. ef. 7-9-13 thru 1-3-14

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Landscape Architect Board
Chapter 804

Rule Caption: Inactive Status and Continuing Education Exemptions for military service, illness, or other circumstances
Adm. Order No.: LAB 2-2013(Temp)
Filed with Sec. of State: 6-20-2013
Certified to be Effective: 6-20-13 thru 12-17-13
Notice Publication Date:
Rules Amended: 804-003-0000, 804-025-0010
Subject: Amends the definition of "in good standing" to clarify that a registrant must be in compliance with continuing education requirements (CE) to be eligible for inactive status under ORS 671.376(4) as opposed to needing to have completed all CE requirements for that renewal cycle. This change thereby allows a registrant who has not completed all CE requirements and suddenly has the need for being exempt from those requirements under OAR 804-025-0010(1) to qualify to request inactive status under ORS 671.376(4) without having to first complete all professional development hours of CE for that renewal cycle. Clarifies in the continuing education requirements rule that the registrant may request inactive status and specifies parameters related to inactive status.
Rules Coordinator: Christine Valentine—(503) 589-0093

804-003-0000
Definitions

The definitions of terms used in ORS 671.310 to 671.459, and the rules of this chapter are:

(1) "Assumed or Fictitious Name" — A false name taken as one's own.

(2) "Business entity" — A sole proprietor Landscape Architect operating under either the registrant name or an assumed business name or any corporation, limited liability company, partnership, or other entity or association of persons providing landscape architectural design or consulting services.

(3) "Deceit" — An attempt to portray as true or valid something that is untrue or invalid.

(4) "Delinquent" — A registrant who fails to renew his/her certificate on or before the renewal date.

(5) "Emeritus" — Retired but retaining an honorary title corresponding to that held immediately before retirement.

(6) "Employing" — Hiring a person, not an independent contractor, for compensation.

(7) "Fraud" — Intentional perversion of truth in order to induce another to part with something of value or to surrender a legal right.

(8) "Grossly Negligent" — Reckless and wanton disregard for exercising care and caution.

(9) "Impersonate" — To assume, without authority or with fraudulent intent, the identity of another person.

(10) "In good standing" — For purposes of ORS 671.376(4) and OAR 804-022-0025(1), 'in good standing' means that the registrant when making the request for inactive status has a current active unrestricted registration; is in compliance with all requirements for registration including, but not limited to, payment of all required fees and compliance with all continuing education requirements; and is not the subject of a pending board investigation or action or the subject of a board order.

(11) Late fee: a fee assessed when a payment is received after the date due.

(12) "Material Misrepresentation" — An untrue statement that is significant under the circumstances.

(13) "Renewal of Registration" — To annually maintain the current status of a valid registration or to bring a delinquent certificate of registration to current, valid status.

Stat. Auth.: ORS 183.335(5), 670.310, 671.415

Stats. Implemented: 671.310–459
Hist.: LAB 1-1984, f. & ef. 1-5-84; LAB 1-1985, f. & ef. 7-1-85; LAB 2-1986, f. & ef. 3-5-86; LAB 1-1989, f. 4-4-89, cert. ef. 4-7-89; LAB 1-2005, f. & cert. ef. 2-14-05; LAB 3-2006, f. & cert. ef. 8-14-06; LAB 1-2010, f. & cert. ef. 2-17-10; LAB 2-2010, f. & cert. ef. 10-19-10; LAB 2-2013(Temp), f. & cert. ef. 6-20-13 thru 12-17-13

804-025-0010
Continuing Education Requirements

(1) Exemptions: A registrant may be exempt, upon board review and approval, from continuing education requirements in any of the following situations:

(a) A registrant is called to active duty in the armed forces of the United States for a period of time exceeding 120 consecutive days in a calendar year. This registrant may request an exemption from obtaining one-half of the required continuing education during that renewal period. Alternatively, the registrant may request to be placed on inactive status under ORS 671.376(4). If the registrant on inactive status requests to return to active practice, the registrant shall complete all professional development hours as required by 804-025-0015.

(b) A registrant experiences physical disability, illness, or other extenuating circumstances that prevents the registrant from practicing landscape architecture. The registrant shall provide supporting documentation for the board's review and approval of the medical exemption. Alternatively, the registrant may request to be placed on inactive status under ORS 671.376(4). If the registrant on inactive status elects to return to active practice, the registrant shall complete all professional development hours as required by 804-025-0015.

(c) A registrant on inactive status must return to active status within 5 years of being placed on inactive status or the registration will lapse and cannot be renewed.

(2) Records: each registrant shall maintain:

(a) A log showing the subject and type of activity claimed, the sponsoring organization, location, duration and instructor's or speaker's name.

(b) Documentation sufficient to prove completion of the activity claimed such as attendance verification records, completion certificates or other documents;

(c) Required log and documentation for at least four (4) years.

(3) Audit: Upon request, each registrant shall provide proof of satisfying the continuing education requirements. If the registrant fails to furnish the information as required by the board or if the information is not sufficient to satisfy the requirements, the license shall not be renewed.

(4) Disallowance: If the board disallows one or more continuing education activities claimed, the board may, at its discretion, allow the registrant up to 120 days after notification to substantiate the original claim or to complete other continuing education activities sufficient to meet the minimum requirements.

Stat. Auth.: ORS 183.335(5), 670.310, 671.376, 671.395, 671.415
Stat. Implemented: ORS 671.376, 671.395
Hist.: LAB 1-2005, f. & cert. ef. 2-14-05; LAB 4-2008, f. & cert. ef. 11-7-08; LAB 2-2013(Temp), f. & cert. ef. 6-20-13 thru 12-17-13

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Rule Caption: Updates to rules for initial registration and registration by reciprocity
Adm. Order No.: LAB 3-2013(Temp)
Filed with Sec. of State: 6-20-2013
Certified to be Effective: 6-20-13 thru 12-17-13
Notice Publication Date:
Rules Amended: 804-022-0005, 804-022-0010
Subject: OSLAB amends its rules for initial registration and registration by reciprocity to increase clarity for prospective applicants and to address an unintended disconnect between Board rules that set forth requirements for examination applicants to obtain approval of alternative paths to licensure (OAR 804-010-0010 and 804-010-0020) and its registration rules (OAR 804-022-0005 and 804-022-0010). The rules clarify that OSLAB does in fact offer paths to registration for applicants without a Landscape Architect Accreditation Board (LAAB) accredited degree or any degree, regardless of whether such individuals obtained approval of alternative education and/or experience from OSLAB prior to taking exams. To this end, the existing rule language is deleted in full and replaced with language that the Board finds to be more complete, clear, and better organized.
Rules Coordinator: Christine Valentine—(503) 589-0093

804-022-0005
Initial Landscape Architect Registration not by Reciprocity

(1) An individual may apply for registration as a Landscape Architect.

(2) The application must include the following:

(a) Completed and signed application form;

(b) Application Fee;

(c) Annual Registration Fee;

(d) Signed Statement of Understanding; and

(e) Sufficient information to demonstrate that the applicant meets Board standards for examination, education, and work experience under subsections (3), (4), or (5) of this rule.

(A) The applicant may submit a CLARB Council Record to demonstrate the examination, education, and work experience qualifications.

(i) Information presented on the CLARB Council Record is subject to verification by the Board.

(ii) The Board may request additional documentation or information from the applicant as the Board or its staff deem necessary for verification of the applicant's qualifications. An application is deemed incomplete until the applicant has provided all requested documentation and information.

(3) Standard Registration Path, LAAB Degree: Minimum of 8 years of landscape architecture experience is required for registration, with 5 years of experience granted for any LAAB degree and 3 years of work experience required under a licensed or registered landscape architect.

(a) Exams: Passage of the Landscape Architect Registration Examination (LARE) or the equivalent from previous versions of the national exam. The applicant must verify passage of all sections of the national exam.

(b) Education: A degree from a LAAB accredited university program. The applicant must provide an official transcript in the university sealed envelope to verify award of a LAAB degree. Any LAAB degree is granted 5 years of credit.

(c) Work Experience: A minimum of three years of work experience under the direct supervision of a licensed or registered Landscape Architect which was obtained after satisfying the requirements of OAR 804 division 10 and (3)(b) of this rule. The applicant must provide a work history summary and work experience verification forms.

(A) Up to two years of the three years of experience may be supervised by a licensed or registered Engineer or Architect;

(4) Non LAAB Degree Path: Minimum of 8 years of landscape architecture experience is required for registration, with 5 years of experience for a degree and work experience with an additional 3 years of work experience required under a licensed or registered landscape architect.

(a) Exams: Passage of the Landscape Architect Registration Examination (LARE) or the equivalent from previous versions of the national exam. The applicant must verify passage of all sections of the national exam.

(b) Education and Equivalent Experience: In the absence of a degree from a LAAB accredited university program, 5 years of credit for education and experience combined as specified in OAR 804-010-0010. The applicant must provide an official transcript in the university sealed envelope to verify award of a degree. The applicant must also provide a work history summary and work experience verification forms.

(A) Experience used to satisfy the education requirement cannot be used towards the work experience requirement of (4)(c) of this rule.

(c) Work Experience: A minimum of three years of work experience under the direct supervision of a licensed or registered Landscape Architect which was obtained after satisfying the requirements of OAR 804 division 10 and (4)(b) of this rule. The applicant must provide a work history summary and work experience verification forms.

(A) Up to two years of the three years of experience may be supervised by a licensed or registered Engineer or Architect;

(5) No Degree Path: Minimum of 11 years of landscape architecture experience is required for registration.

(a) Exams: The Board requires passage of the Landscape Architect Registration Examination (LARE) or the equivalent from previous versions of the national exam. The applicant must verify passage of all sections of the national exam.

(b) Experience In Lieu of Education: In the absence of any degree, 8 years of work experience under the supervision of a licensed or registered Landscape Architect. The applicant must provide a work history summary and work experience verification forms.

(A) Experience used to satisfy this requirement cannot be used towards the work experience requirement of (5)(c) of this rule.

(c) Work Experience: A minimum of three years of work experience under the direct supervision of a licensed or registered Landscape Architect

which was obtained after satisfying the requirements of OAR 804 division 10 and (5)(b) of this rule. The applicant must provide a work history summary and work experience verification forms.

(A) Up to two years of the three years of experience may be supervised by a licensed or registered Engineer or Architect;

(6) Upon acceptance by the Board, the applicant is required to complete an Oral Exam.

(7) The initial date of registration shall be the date of the meeting during which the Board approves the application for registration.

Stat. Auth.: ORS 183.335(5), 670.310, 671.325, 671.335, 671.415
Stats. Implemented: ORS 671.316, 671.325, 671.335
Hist.: LAB 1-2007, f. & cert. ef. 4-27-07; LAB 1-2012, f. 5-17-12, cert. ef. 6-1-12; LAB 3-2013(Temp), f. & cert. ef. 6-20-13 thru 12-17-13

804-022-0010
Landscape Architect Registration by Reciprocity

(1) Any person not registered as a Landscape Architect in Oregon, but who currently holds a license or registration to practice as a Landscape Architect in another state or territory, may file an application for registration by reciprocity under ORS 671.345 and the requirements of this rule.

(2) An application must include the following:

(a) Completed and signed application form;

(b) Application Fee;

(c) Annual Registration Fee;

(d) Signed Statement of Understanding;

(e) Identification of all states in which licensure is currently held, with official verification from the licensing state and where exams were passed; and

(f) Sufficient information to demonstrate that the applicant meets Board standards for examination, education, and work experience under subsections (3), (4), or (5) of this rule.

(A) The applicant may submit a CLARB Council Record to demonstrate the examination, education, and work experience qualifications.

(i) Information presented on the CLARB Council Record is subject to verification by the Board.

(ii) The Board may request additional documentation or information from the applicant as the Board or its staff deem necessary for verification of the applicant's qualifications. An application is deemed incomplete until the applicant has provided all requested documentation and information.

(3) Standard Registration Path: Minimum of 8 years of landscape architecture experience is required for registration, with 5 years of experience granted for an LAAB degree and 3 years of work experience required under a licensed or registered landscape architect.

(a) Exams: Passage of the Landscape Architect Registration Examination (LARE) or the equivalent from previous versions of the national exam. The applicant must verify passage of all sections of the national exam.

(b) Education: A degree from a LAAB accredited university program. The applicant must provide an official transcript in the university sealed envelope to verify award of a LAAB degree. Any LAAB degree is granted 5 years of credit.

(c) Work Experience:

(A) A minimum of three years of work experience under the direct supervision of a licensed or registered Landscape Architect which was obtained after satisfying the education requirements of OAR 804 division 10 and (3)(b) of this rule. The applicant must provide a work history summary and work experience verification forms. Up to two years of the three years of experience may be supervised by a licensed or registered Engineer or Architect; or

(B) A minimum of 11 years of work experience as a Landscape Architect licensed or registered in another U.S. state or territory verified as follows:

(i) A minimum of three professional reference letters in a form acceptable to the Board signed by licensed or registered Landscape Architects, Engineers, or Architects and submitted to the Board; and

(ii) A resume of the applicant detailing the 11 years of verified work experience.

(4) Non LAAB Degree Path: Minimum of 8 years of landscape architecture experience is required for registration, with 5 years of experience for a degree and work experience with an additional 3 years of work experience required under a licensed or registered landscape architect.

(a) Exams: Passage of the Landscape Architect Registration Examination (LARE) or the equivalent from previous versions of the national exam. The applicant must verify passage of all sections of the national exam.

(b) Education and Equivalent Experience: In the absence of a degree from a LAAB accredited university program, 5 years of credit for education and experience combined as specified in OAR 804-010-0010. The applicant must provide an official transcript in the university sealed envelope to verify award of a degree. The applicant must also provide a work history summary and work experience verification forms.

(A) Experience used to satisfy the education requirement cannot be used towards the work experience requirement of (4)(c) except as provided in (4)(c)(B) of this rule.

(c) Work Experience:

(A) A minimum of three years of work experience under the direct supervision of a licensed or registered Landscape Architect which was obtained after satisfying the requirements of OAR 804 division 10 and (4)(b) of this rule. The applicant must provide a work history summary and work experience verification forms. Up to two years of the three years of experience may be supervised by a licensed or registered Engineer or Architect; or

(B) A minimum of 11 years of work experience as a Landscape Architect licensed or registered in another U.S. state or territory verified as follows:

(i) A minimum of three professional reference letters in a form acceptable to the Board signed by licensed or registered Landscape Architects, Engineers, or Architects and submitted to the Board; and

(ii) A resume of the applicant detailing the 11 years of verified work experience.

(5) No Degree Path: Minimum of 11 years of landscape architecture experience is required for registration.

(a) Exams: Passage of the Landscape Architect Registration Examination (LARE) or the equivalent from previous versions of the national exam. The applicant must verify passage of all sections of the national exam.

(b) Experience in Lieu of Education: In the absence of any degree, 8 years of work experience under the supervision of a licensed or registered Landscape Architect or a minimum of 11 years of work experience as a Landscape Architect licensed or registered in another U.S. state or territory. The applicant must also provide a work history summary and work experience verification forms.

(A) Experience used to satisfy this requirement cannot be used towards the work experience requirement of (5)(c) except as provided in (5)(c)(B).

(c) Work Experience:

(A) A minimum of three years of work experience under the direct supervision of a licensed or registered Landscape Architect which was obtained after satisfying the requirements of OAR 804 division 10 and (5)(b) of this rule. The applicant must provide a work history summary and work experience verification forms. Up to two years of the three years of experience may be supervised by a licensed or registered Engineer or Architect; or

(B) A minimum of 11 years of work experience as a Landscape Architect licensed or registered in another U.S. state or territory verified as follows:

(i) A minimum of three professional reference letters in a form acceptable to the Board signed by licensed or registered Landscape Architects, Engineers, or Architects and submitted to the Board; and

(ii) A resume of the applicant detailing the 11 years of verified work experience.

(6) Registration may be granted without oral exam after all application materials are approved.

Stat. Auth.: ORS 183.335(5), 670.310, 671.325, 671.335, 671.415
Stats. Implemented: ORS 671.345
Hist.: LAB 1-1983, f. & ef. 2-1-83; LAB 1-1984, f. & ef. 1-5-84; LAB 2-1989, f. 7-1-89, cert. & ef. 6-23-89; LAB 2-1989, f. 6-23-89, cert. ef. 7-1-89; LAB 1-1993, f. & cert. ef. 7-1-93; LAB 2-1998, f. & cert. ef. 4-22-98; Renumbered from 804-010-0025, LAB 1-2007, f. & cert. ef. 4-27-07; LAB 1-2008, f. & cert. ef. 2-4-08; LAB 1-2012, f. 5-17-12, cert. ef. 6-1-12; LAB 3-2013(Temp), f. & cert. ef. 6-20-13 thru 12-17-13

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Landscape Contractors Board
Chapter 808

Rule Caption: Adopts July 1, 2013 through June 30, 2015 budget.
Adm. Order No.: LCB 3-2013
Filed with Sec. of State: 6-21-2013
Certified to be Effective: 7-1-13
Notice Publication Date: 5-1-2013
Rules Amended: 808-001-0008

Subject: Adopts July 1, 2013 through June 30, 2015 budget.
Rules Coordinator: Kim Gladwill-Rowley—(503) 967-6291, ext. 223

808-001-0008
Operating Budget

Pursuant to ORS 182.462, the Board adopts the budget, for the biennium beginning July 1, 2013 and ending June 30, 2015, as approved at a Board Meeting held June 20, 2013. The amended budget is effective July 1, 2013. The Board Administrator will add or amend accounts as necessary, within the approved budget amount for the effective operation of the Board. Copies of the budget are available at the Board's office.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 670.310 & 671.670
Stats. Implemented: ORS 182.462
Hist.: LCB 3-2003, f. 5-27-03, cert. ef. 6-1-03; LCB 3-2005, f. & cert. ef. 6-1-05; LCB 1-2006, f. 3-27-06, cert. ef. 4-1-06; LCB 2-2007, f. & cert. ef. 5-16-07; LCB 4-2009, f. 6-1-09 cert. ef. 7-1-09; LCB 5-2011, f. & cert. ef. 6-17-11; LCB 5-2012, f. & cert. ef. 8-2-12; LCB 3-2013, f. 6-21-13, cert. ef. 7-1-13

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Oregon Board of Dentistry
Chapter 818

Rule Caption: Temporary rule regarding the implementation of End Tidal CO2 monitoring effective December 29, 2013.
Adm. Order No.: OBD 2-2013(Temp)
Filed with Sec. of State: 7-1-2013
Certified to be Effective: 7-1-13 thru 12-28-13
Notice Publication Date:
Rules Adopted: 818-026-0140
Subject: The Board is creating Temporary Rule 810-026-0140 Implementation Date of End Tidal CO2 Monitoring.
Rules Coordinator: Stephen Prisby—(971) 673-3200

818-026-0140
Implementation Date of End Tidal CO2 Monitoring

The requirement to have patients continuously monitored with End-tidal CO2 monitors as provided in OAR 818-026-0060(7)(a), 818-026-0065(7)(a) and 818-026-0070(7)(a) will become effective on December 29, 2013.

Stat. Auth.: ORS 679.250(7)
Stats. Implemented: ORS 679.250
Hist.: OBD 2-2013(Temp), f. & cert. ef. 7-1-13 thru 12-28-13

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Oregon Business Development Department
Chapter 123

Rule Caption: The rules relating to the Oregon Business Development Fund have been amended or repealed.
Adm. Order No.: OBDD 6-2013
Filed with Sec. of State: 7-1-2013
Certified to be Effective: 7-1-13
Notice Publication Date: 6-1-2013
Rules Amended: 123-017-0015, 123-017-0030, 123-017-0035, 123-017-0055
Rules Repealed: 123-017-0060, 123-017-0070, 123-017-0080
Subject: The Oregon Business Development Fund rules are amended to include new language for eligibility. The condition for approval that states applicants have not entered into a contract or contracts exceeding $700,000 has been amended to $1,000,000. The maximum loan contract amount has been amended from $700,000 to $1,000,000. Payment schedule language has been amended.

The Building Opportunities for Oregon Small Business Today (BOOST) program is statutorily mandated to expire on June 30, 2013. The BOOST rules have been repealed.
Rules Coordinator: Mindee Sublette—(503) 986-0036

123-017-0015
Eligibility

(1) Eligible projects are business development projects as defined in OAR 123-017-0010(2). If the Department is unable to obtain a sufficient number of approvable applications to meet the requirements of ORS 285B.059(5), it may, notwithstanding the limitations imposed by 285B.050(2)(g)(B), make loans to service and retail businesses operated by emerging small businesses which are located in or draw their workforces from within distressed areas as determined by the Department, when such projects provide compelling economic development benefits. The amount of loans the Department may make to service and retail businesses under (1) of this section shall be limited to the amount calculated under the method described in 285B.059(5).

(2) Eligible purposes are the financing of land, buildings, fixture, equipment and machinery, research and development, and the provision of working capital.

(3) Eligible applicants are defined in OAR 123-017-0010(1).

(4) The relocation of a facility from one labor market area to another, if not accompanied by an expansion of the applicant's business or employment, is an eligible activity if:

(a) The relocation is caused by forces beyond the control of the applicant; or

(b) The relocation is necessary for the continued operation of the business; or

(c) There is no resulting loss of employment at the former site of the business.

(5) Relending of funds shall not be an eligible activity, except that the funds may be used for the local injection share of an SBA 503 or 504 Certified Development Company transaction.

(6) In cases where an otherwise eligible company or project has an insignificant (less than 25 percent) ineligible portion, the entire project may be determined eligible for a loan from the fund.

(7) Other than as specified in section (6) and (10) of this rule, Fund financing will be limited to 40 percent of the amount of the eligible costs, except that Fund financing may equal up to 50 percent of eligible costs when the application is submitted through or referral for financing is made to the Department by a Financial Institution.

(8) Tourist facilities shall not be eligible unless:

(a) The project can be qualified as a convention center; or

(b) The project can be qualified as a destination attraction with significant regional economic impact.

(9) Refinancing of existing debt, including existing trade payables and delinquent taxes, shall not be eligible unless the applicant demonstrates to the satisfaction of the Finance Committee that:

(a) The applicant contributes significantly to a target population or to a geographical area targeted by the Oregon Business Development Fund;

(b) The applicant requires refinancing to remain viable. Assessment of viability will be made at the sole discretion of the Finance Committee;

(c) Lenders agree to extend due dates, provide additional financing or provide other favorable terms to the applicant; and

(d) The applicant meets all other requirements set forth in statute and administrative rule, including demonstrating to the satisfaction of the Finance Committee that the project is feasible and a reasonable risk, has a reasonable prospect of repayment and can provide good and sufficient collateral.

(10) Except for the Oregon Targeted Development Account, Fund financing may exceed 50 percent of the amount of the eligible project costs and/or may be approved without a commitment from a commercial or private lender, or a local development group, to participate in the financing of the project, if

(a) Two or more Financial Institutions have denied a financing request for the project by the borrower. Such denied financing request must:

(A) Be for a loan for an eligible Fund loan purpose; and

(B) Be evidenced by a written denial from the Financial Institution specifying the reason(s) for the denial. Denial for reasons such as an incomplete application, failure to provide requested information, or the requested loan is for a purpose for which or on terms under which the Financial Institution does not make loans is not acceptable as a denial of financing; and

(b) The applicant certifies that there is no other available financing for the project with documentation as required by the Finance Committee.

(11) Fund financing may be approved without a commitment from a commercial or private lender or a local development group to participate in the financing of the project if the applicant is a county or municipality, or if there are required forms of payments other than scheduled principal and interest.

Stat. Auth.: ORS 285A.075
Stats. Implemented: ORS 285B.059, 285B.080(3) & 285B.092
Hist.: EDD 2-1983(Temp), f. & ef. 5-25-83; EDD 1-1984, f. & ef. 1-5-84; EDD 10-1988, f. & cert. ef. 3-18-88; EDD 37-1988, f. & cert. ef. 12-15-88; EDD 9-1989(Temp), f. & cert. ef. 11-3-89; EDD 5-1990, f. & cert. ef. 3-5-90; EDD 25-1990 (Temp), f. & cert. ef. 9-13-90; EDD 29-1990, f. & cert. ef. 12-12-90; EDD 6-1991(Temp), f. & cert. ef. 6-18-91; EDD 8-1996(Temp), f. & cert. ef. 8-13-96; EDD 4-1997, f. & cert. ef. 3-25-97; EDD 9-1997(Temp), f. & cert. ef. 10-7-97; EDD 8-1998, f. & cert. ef. 5-22-98; EDD 11-1999, f. & cert. ef. 10-11-99; EDD 6-2001, f. & cert. ef. 10-9-01; EDD 6-2007(Temp), f & cert. ef. 8-29-07 thru 2-23-08; EDD 3-2008(Temp), f. & cert. ef. 2-26-08 thru 8-1-08; EDD 21-2008, f. 7-31-08, cert.

ef. 8-1-08; EDD 22-2009, f. 11-30-09, cert. ef. 12-1-09; OBDD 9-2010(Temp), f. & cert. ef. 4-12-10 thru 10-9-10; OBDD 20-2010(Temp), f. & cert. ef. 5-28-10 thru 10-9-10; OBDD 33-2010, f. & cert. ef. 10-1-10; OBDD 6-2013, f. & cert. ef. 7-1-13

123-017-0030
Loan Conditions

(1) The Director (for loan requests of $250,000 or less) or the Finance Committee may approve a loan request if it finds that:

(a) Fund participation in any financing shall not exceed 40 percent of the total amount of the eligible project costs, except that Fund financing may be up to 50 percent when an application is submitted through a Financial institution or Fund financing may exceed 40 percent when two or more Financial Institutions have denied financing as outlined in OAR 123-017-0015(10).

(b) The proposed business development project is feasible and a reasonable risk from practical and economic standpoints, and the loan has reasonable prospect of repayment.

(c) The applicant can provide good and sufficient collateral for the loan, as determined by the Commission. The Commission's security interest may be subordinated to the security interest of other lenders participating in the project. The security interest of loans from the Oregon Targeted Development Account will not be subordinated to the security interest of other lenders, unless the Finance Committee or the Director finds there is an abundance of collateral and/or company or guarantor financial strength. The Business Development Commission may make loans in distressed areas, as defined by the Department, without regard to the requirements for security and collateral under ORS 285B.059 and 285B.062 that are otherwise applicable. Collateral value of out-of-state real property will be significantly discounted from nominal assessed or appraised value.

(d) Monies in the Oregon Business Development Fund are or will be available for the proposed business development project.

(e) There is a need for the proposed business development project.

(f) The applicant's financial resources are adequate to ensure success of the project.

(g) The applicant has not received or entered into a contract or contracts exceeding $1,000,000 with the Commission, under authority of ORS 285B.050–285B.098, for the previous 365 days.

(2) The Finance Committee may, in its sole discretion, permit the assumption of an outstanding Oregon Business Development Fund Loan, if the assuming obligor satisfies the Finance Committee or the Director as to its willingness and ability to perform all obligations of the original borrower related to the loan, including but not limited to the obligation to repay the loan in accordance with its terms, and if the State's collateral position is not diminished. Oregon Business Development Fund loans are not, however, necessarily or automatically assumable. A complete application, application fee and supporting documentation are required to initiate review of the request.

(3) The applicant agrees to abide by all laws and regulations applicable to the applicant's project.

Stat. Auth.: ORS 285A.075
Stats. Implemented: ORS 285B.059 & 285B.092
Hist.: EDD 2-1983(Temp), f. & ef. 5-25-83; EDD 1-1984, f. & ef. 1-5-84; EDD 10-1988, f. & cert. ef. 3-18-88; EDD 37-1988, f. & cert. ef. 12-15-88; EDD 9-1989(Temp), f. & cert. ef. 11-3-89; EDD 5-1990, f. & cert. ef. 3-5-90; EDD 8-1996(Temp), f. & cert. ef. 8-13-96; EDD 4-1997, f. & cert. ef. 3-25-97; EDD 9-1997(Temp), f. & cert. ef. 10-7-97; EDD 8-1998, f. & cert. ef. 5-22-98; EDD 11-1999, f. & cert. ef. 10-11-99; EDD 6-2001, f. & cert. ef. 10-9-01; EDD 5-2005, f. & cert. ef. 5-11-05; EDD 6-2007(Temp), f & cert. ef. 8-29-07 thru 2-23-08; EDD 3-2008(Temp), f. & cert. ef. 2-26-08 thru 8-1-08; EDD 21-2008, f. 7-31-08, cert. ef. 8-1-08; EDD 22-2009, f. 11-30-09, cert. ef. 12-1-09; OBDD 9-2010(Temp), f. & cert. ef. 4-12-10 thru 10-9-10; OBDD 20-2010(Temp), f. & cert. ef. 5-28-10 thru 10-9-10; OBDD 33-2010, f. & cert. ef. 10-1-10; OBDD 6-2013, f. & cert. ef. 7-1-13

123-017-0035
Loan Agreement

If the Finance Committee approves the business development project, the Finance Committee or the Director, on behalf of the state, and the borrower may enter into a loan contract of not more than $1,000,000, secured by good and sufficient collateral (except as noted in OAR 123-017-0030(1)(c)), as determined by the Finance Committee, that shall set forth, among other matters:

(1) A plan for repayment by the borrower to the Oregon Business Development Fund moneys borrowed from the Fund used for the business development project with interest charged on those moneys at the fixed rate of one percentage point more than the prevailing interest rate on United States Treasury bills, notes or bonds of a comparable maturity. Loans made from the Oregon Targeted Development Account shall be made at a fixed interest rate of four percentage points less than the prevailing prime rate. Loans made under the conditions of OAR 123-0017-0015(10) shall be made at a fixed interest rate of not less than five percentage points over the prevailing prime rate. The rate shall not be less than four percent. For the purposes of this section, the prevailing interest rate shall be the weekly average interest rate as set forth in the most recent Federal Reserve Statistical Release H.15(519) that the Department has received at the time the loan is approved. The repayment plan, among other matters:

(a) Shall provide for commencement of repayment by the applicant of moneys used for the business development project and interest thereon no later than one year after the date of the loan contract or at such other time as the Finance Committee may provide;

(b) May provide for reasonable extension of the time for making any repayment in emergency or hardship circumstances if approved by the Finance Committee or the Director;

(c) Shall provide for such evidence of debt assurance of, and security for, repayment of the loan as is considered necessary by the Finance Committee;

(d) Shall set forth a schedule of payments and the period of loan which shall not exceed the usable life of the contracted project or 25 years from the date of the contract, whichever is less. The payment schedule shall include repayment of interest that accrues during any period of delay in repayment authorized by subsection (a) of this section, and the payment schedule may require payments of varying amounts for collection of accrued interest. The term of the Fund loan will normally be matched to, and not exceed twice that of, the commercial or private lender participating in the project, if applicable. Loans from the Oregon Targeted Development Account shall be for a maximum term of 5 years, with a maximum amortization of 15 years. Loans made under the terms of OAR 123-017-0015(10) shall be for a maximum term of 5 years, with a maximum amortization of 20 years.

(e) A request to renew any loan from the Fund that has reached its scheduled maturity and has not been repaid in full may be approved by the Finance Committee (or Director if the principal balance does not exceed $250,000), with any additional terms and conditions, including interest rate, that it may determine. A new application, including an application fee and supporting documentation, are required to initiate review of the request.

(f) Shall set forth a procedure for formal declaration of delinquency or default of payment by the Department. Loans shall be declared delinquent when any payment is more than ten days late. Borrower shall be notified in writing of declaration of delinquency, and shall have 31 days from the original payment date to bring the loan current. If the loan is not brought current, or arrangements satisfactory to the Department for bringing the loan current have not been made, the Department may declare the loan in default, declare the entire outstanding indebtedness to be forthwith due and payable and assign the loan to the Attorney General for collection; The Finance Committee or the Director or their designee is authorized to approve any modification of terms on a loan that is delinquent or in default as deemed necessary or prudent to most likely effect repayment of the loan to the Fund.

(g) May allow for forms of payment on loans other than scheduled principal and interest payments, as determined by the Finance Committee, or Director in the case of loans of $250,000 or less.

(2) Provisions satisfactory to the Department for field engineering and inspection, the Department to be the final judge of completion of the contract.

(3) That the liability of the state under the contract is contingent upon the availability of moneys in the Oregon Business Development Fund for use in the business development project.

(4) Such further provisions as the Finance Committee considers necessary to ensure expenditure of the funds for the purposes set forth in the approved application.

(5) That the borrower is responsible for payment of:

(a) All of the expenses of the operation and maintenance of the project, including adequate insurance;

(b) All taxes and special assessments levied with respect to the leased premises and payable during the term of the lease;

(c) Insurance premiums and providing insurance in amount and coverage acceptable to the Finance Committee. Such insurance shall include but shall not be limited to: fire and hazard insurance, liability insurance and flood insurance (if applicable); and

(d) Out-of-pocket costs associated with the loan closing which may include but are not limited to filing and recording fees, title insurance and appraisals, and attorney fees.

(6) That the borrower will provide to the Department on an annual basis, within 120 days of the end of its fiscal year, the same type of financial statements as required by the participating bank. The Finance Committee or the Department may require additional financial information.

(7) The Finance Committee, or Director for loans under $250,000, may require an assignment of life insurance on active principals in borrower.

(8) The Department, at its sole discretion, may require the execution of a Commitment Letter and receipt of a non-refundable Commitment Fee to secure resources necessary to fund the loan. The Commitment Fee will be applied at closing to the loan fee. If the loan does not close, the Commitment Fee will not be refunded.

(9) In the case of loans of more than $100,000 that are funded by proceeds from the Oregon Lottery, that the borrower shall make a good faith effort to hire and retain low-income individuals who have received job training assistance from publicly funded job training providers and enter into a first-source hiring agreement with a publicly funded job training provider.

(10) If the loan will result in the construction, expansion, rehabilitation or remodeling of a facility to which the public has access, adequate access for handicapped persons must be provided. This provision applies only to firms that deal directly with the general public in the normal and usual course of their business, and to facilities in which business is customarily transacted by and with members of the general public.

(11) If a project involves building construction, expansion, rehabilitation or modification, a loan from the fund shall be permanent and not interim financing.

Stat. Auth.: ORS 285A.075

Stats. Implemented: ORS 285B.062 & 285B.092

Hist.: EDD 2-1983(Temp), f. & ef. 5-25-83; EDD 1-1984, f. & ef. 1-5-84; EDD 10-1988, f. & cert. ef. 3-18-88; EDD 37-1988, f. & cert. ef. 12-15-88; EDD 9-1989(Temp), f. & cert. ef. 11-3-89; EDD 5-1990, f. & cert. ef. 3-5-90; EDD 25-1990 (Temp), f. & cert. ef. 9-13-90; EDD 29-1990, f. & cert. ef. 12-12-90; EDD 8-1996(Temp), f. & cert. ef. 8-13-96; EDD 4-1997, f. & cert. ef. 3-25-97; EDD 9-1997(Temp), f. & cert. ef. 10-7-97; EDD 8-1998, f. & cert. ef. 5-22-98; EDD 11-1999, f. & cert. ef. 10-11-99; EDD 6-2001, f. & cert. ef. 10-9-01; EDD 5-2005, f. & cert. ef. 5-11-05; EDD 6-2007(Temp), f & cert. ef. 8-29-07 thru 2-23-08; EDD 3-2008(Temp), f. & cert. ef. 2-26-08 thru 8-1-08; EDD 21-2008, f. 7-31-08, cert. ef. 8-1-08; EDD 22-2009, f. 11-30-09, cert. ef. 4-12-10 thru 10-9-10; OBDD 20-2010(Temp), f. & cert. ef. 5-28-10 thru 10-9-10; OBDD 33-2010, f. & cert. ef. 10-1-10; OBDD 6-2013, f. & cert. ef. 7-1-13

123-017-0055

Fees and Charges

(1) The Department shall charge and collect a loan fee of $200 at the time the application is filed.

(2) In addition, the applicant, immediately upon receiving the loan proceeds, shall pay to the Department one and one-half percent of the principal amount of the loan.

(3) The Department may charge and collect a Commitment Fee, payable to the Department, in an amount up to three quarters of one percent of the principal amount of the loan to be applied to the fee specified in section (2) of this rule at closing of the loan. If the loan does not close, the Commitment Fee will not be refunded.

(4) The Department may charge and collect an Assumption Fee, payable to the Department, in an amount up to one half of one percent of the remaining principal balance of the loan. The individual or entity assuming the obligation will also be responsible for closing costs associated with the transfer of debt including but not limited to document preparation, review of documentation for legal sufficiency, title, escrow, recording or filing fees.

(5) The Department may charge and collect a Loan Modification Fee, payable to the Department, of $50 at the time of the modification request. A loan modification may include, but, is not limited to, modification to terms of repayment, subordination requests or collateral swaps. The individual or entity requesting the modification will also be responsible for costs associated with the modification including, but, not limited to, document preparation, review of documentation for legal sufficiency, title, escrow, recording or filing fees.

(6) Monies referred to in (1), (2), (3), (4) and (5) of this section shall be paid into the Fund.

(7) The Department may, in its sole discretion, use some or all of the money collected under section (2) of this rule, plus a maximum of an additional one and one-half percent, as payment to a contracted local development group for referring projects for financing, packaging the loans, processing applications, investigating proposed business development projects and servicing outstanding loans. In no case shall the Department make any payment of more than $10,000 for any one project. In no case shall the Department make any payment to any third party until the loan has been closed and the Department has collected the fee specified in section (2) of this rule.

Stat. Auth.: ORS 285A.075

Stats. Implemented: ORS 285B.056, 285B.068 & 285B.092

Hist.: EDD 2-1983(Temp), f. & ef. 5-25-83; EDD 1-1984, f. & ef. 1-5-84; EDD 10-1988, f. & cert. ef. 3-13-88; EDD 37-1988, f. & cert. ef. 12-15-88; EDD 5-1990, f. & cert. ef. 3-5-90; EDD 11-1999, f. & cert. ef. 10-11-99; EDD 6-2001, f. & cert. ef. 10-9-01; EDD 6-2007(Temp), f & cert. ef. 8-29-07 thru 2-23-08; EDD 3-2008(Temp), f. & cert. ef. 2-26-08 thru 8-1-08; EDD 21-2008, f. 7-31-08, cert. ef. 8-1-08; EDD 22-2009, f. 11-30-09, cert. ef. 12-1-09; OBDD 20-2010(Temp), f. & cert. ef. 5-28-10 thru 10-9-10; OBDD 33-2010, f. & cert. ef. 10-1-10; OBDD 6-2013, f. & cert. ef. 7-1-13

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Oregon Department of Education
Chapter 581

Rule Caption: School and District Performance Report Criteria
Adm. Order No.: ODE 13-2013
Filed with Sec. of State: 7-11-2013
Certified to be Effective: 7-11-13
Notice Publication Date: 6-1-2013
Rules Amended: 581-022-1060
Subject: The rule amendments do the following: Change the ratings applied to schools and districts; change the indicators upon which the ratings are based; require the production of a Policy and Technical Manual; and update the rule to reflect changes in federal law.
Rules Coordinator: Cindy Hunt—(503) 947-5651

581-022-1060

School and District Performance Report Criteria

(1) The Superintendent of Public Instruction will annually collect data and produce annual school district and school performance reports to provide information to parents and to improve schools.

(2) The Superintendent will notify the public and the media by December 15 of each year that school and district performance reports are available at each school and school district and at the Department of Education website and office.

(3) Each school and school district report shall contain the information required by this rule. By January 15 of each year, school districts shall make a copy of the state provided school and school district performance report available to the parent(s) or guardian(s) of each child enrolled in a public school in the school district by doing one or more of the following:

(a) Mailing a copy;

(b) Electronically sending a copy; or

(c) Providing a link to a state or district web site containing the reports and also making copies available in local schools, libraries, parents centers, community centers, or other public locations easily accessible to parents and others.

(4) School performance reports will include ratings assigned by the Superintendent School ratings shall be reported in terms of five levels.

(5) The school rating system will be based upon the following indicators:

(a) Achievement in reading and mathematics.

(b) Growth in reading and mathematics.

(c) Growth for underserved subgroups of students.

(d) Student participation rates in reading and mathematics.

(6) In addition to the indicators listed in subsection (5) of this section, for schools that are high schools or that offer grades 9, 10, 11 or 12 as part of the schools the rating system will also include the following indicators:

(a) Graduation rates for all students.

(b) Graduation rate for underserved subgroups.

(7) School performance reports may include information other than that listed in ORS 329.105 or sections (4), (5) and (6)of this rule. Such information will not be part of the calculation of the school rating.

(8) School district performance reports will be developed and must include the overall rating of each school in the district. The district performance report may include information other than that listed in ORS 329.105 or section (4) or this rule.

(9) School and school districts may include information in addition to that listed in ORS 329.105 or sections (4) and (5) of this rule in their locally prepared and distributed school and school district performance reports.

(10) School and school district performance reports, in conjunction with electronic supplements of the performance reports, will serve as the means by which the state meets the report card requirements of section 1111 of the Elementary and Secondary Education Act of 1965 (ESEA).

(11) The Superintendent shall produce a Policy and Technical Manual to provide school districts and schools with details of the data elements and calculations used the district and school performance reports. The Superintendent shall make the manual available to districts and schools.

Stat. Auth.: ORS 326.051 & 329.075

Stats. Implemented: ORS 329.105

Hist.: ODE 36-1999, f. 12-13-99, cert. ef. 12-14-99; ODE 5-2007, f. & cert. ef. 2-21-07; ODE 25-2008, f. & cert. ef. 9-26-08; ODE 4-2009, f. & cert. ef. 6-29-09; ODE 17-2011, f. 12-15-11, cert. ef. 1-1-12; ODE 13-2013, f. & cert. ef. 7-11-13

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Rule Caption: Allows for reconsideration of agency final orders relating to special education complaints.
Adm. Order No.: ODE 14-2013
Filed with Sec. of State: 7-11-2013
Certified to be Effective: 7-11-13
Notice Publication Date: 1-1-2013
Rules Amended: 581-015-2030
Subject: An organization or individual may file a complaint with the Department of Education that a program or district has violated the Individuals with Disabilities Education Act (IDEA). Under IDEA, the Department is required to issue a final order within 60 days of receiving a complaint.

The rule amendments allow for a party to ask the Department for reconsideration of the final order. Pursuant to federal guidance the rule does not allow the Department to stay the final order pending disposition of the reconsideration request.
Rules Coordinator: Cindy Hunt—(503) 947-5651

581-015-2030
Procedures for Complaints as Required by IDEA Regulations

(1) An organization or individual, including an organization or individual from another state, may file with the State Superintendent of Public Instruction a written, signed complaint that the Department, or a sub grantee, including but not limited to a regional program, an education service district or a local education agency is violating or has violated the Individuals with Disabilities Education Act or regulations under that Act.

(2) The complainant must send a copy of the complaint to the public agency serving the child at the same time the complainant files the complaint with the Department.

(3) Upon receipt of a complaint under this provision, the Department will provide a copy of the Notice of Procedural Safeguards to a parent or adult student who files a complaint.

(4) If a complaint alleges violations outside the scope of the Individuals with Disabilities Education Act, the complainant will be informed of alternative procedures that are available to address the complainant's allegations.

(5) The complaint must allege a violation that occurred not more than one year before the date that the complaint is received by the Department

(6) The complaint must include the facts on which the complaint is based. If the facts as alleged by the complainant would be considered a violation of the Individuals with Disabilities Education Act:

(a) The Superintendent will request the public agency to respond to the allegations. The Superintendent (or designee) may also initiate attempts to resolve the complaint through mediation or alternative dispute resolution, including local resolution.

(b) The respondent must respond to the allegations and furnish any information or documents requested by the Superintendent within ten business days from the receipt of request for response from the Superintendent unless another time period is specified by the Superintendent. At the same time, the respondent must send a copy of the response and documents to the complainant. If the complainant does not otherwise have access to confidential information in the response, the respondent must provide the complainant with the non-confidential portion(s) of the response.

(7) The Superintendent will give the complainant the opportunity to submit additional information, either orally or in writing, about the allegations in the complaint or the public agency's response. The complainant must provide a copy of any further written information to the public agency that is the subject of the complaint, unless it would be a hardship to do so. In those situations, the Department will provide a copy of the written information to the public agency.

(8) The Superintendent will review all of the written information submitted by the complainant and the public agency to resolve the allegations in the complaint.

(9) The Superintendent may conduct further investigation, such as telephone or onsite interviews, to the extent necessary to resolve the complaint allegations.

(10) If a written complaint is received that is also the subject of a due process hearing under OAR 581-015-2345, or contains multiple issues of which one or more are part of that hearing, the Superintendent will set aside any part of the complaint that is being addressed in the due process hearing, until the conclusion of the hearing. Any issue in the complaint that is not a part of the due process hearing will be resolved using the time limit and procedures in this rule.

(11) If an issue raised in a complaint has previously been decided in a due process hearing involving the same parties, the hearing decision is binding and the Superintendent will inform the complainant to that effect. A complaint alleging a school district's failure to implement a due process decision will be resolved by the Superintendent.

(12) The Superintendent will issue a written decision that addresses each allegation in the complaint and contains findings of fact, conclusions, and reasons for the Department's final decision within 60 days of receipt of the complaint unless:

(a) Exceptional circumstances related to the complaint require an extension; or

(b) The complainant and public agency agree in writing to extend the time to try mediation or local resolution.

(13) If the Superintendent finds a violation, the Superintendent's written decision will include any necessary corrective action to be undertaken as well as any documentation to be supplied by any party to ensure that the corrective action has occurred. If the decision is that a school district has failed to provide appropriate services, the Superintendent will address:

(a) How to remediate the failure to provide those services, including, as appropriate, compensatory education, monetary reimbursement or other corrective action appropriate to the needs of the child; and

(b) Appropriate future provision of services for all children with disabilities.

(14)(a) Parties may seek judicial review of the final order under ORS 183.484. Judicial review may be obtained by filing a petition for review within 60 days of service of the final order with the Marion County Circuit Court or with the Circuit Court for the County where the party resides.

(b) Pursuant to OAR 137-004-0080 and ORS 183.484(2), a party to the complaint may request reconsideration of the final order by the Superintendent within 60 days after the date of the order. Except as provided in this subsection, the Superintendent and a party seeking reconsideration shall follow the procedure for reconsideration described in OAR 137-004-0080.

(c) Notwithstanding OAR 137-004-0080, the Superintendent may not stay a final order upon request by a party and any party subject to Corrective Action resulting from the order must commence the Corrective Action according to the final order.

(15) Corrective action ordered by the Superintendent must be completed within the timelines established in the final order unless another time period is specified by the Department.

(16) At any time during the pendency of the complaint, if the Superintendent determines that there is a strong likelihood that the respondent has significantly breached the Individuals with Disabilities Education Act and that delay may cause irreparable harm, the Superintendent may order interim relief.

(17) If the respondent refuses to voluntarily comply with a plan of correction when so ordered, the Superintendent may take one or more of following actions:

(a) Disapprove in whole or part, the respondent's application for federal funding;

(b) Withhold or terminate further assistance to the respondent for an approved project;

(c) Suspend payments, under an approved project, to a respondent;

(d) Order, in accordance with a final state audit resolution determination, the repayment of specified federal funds; and

(e) Withhold all or part of a district's basic school support in accordance with ORS 327.103.

(18) Before the Superintendent denies or withholds funding or orders reimbursement as provided in section (17) of this rule, the Superintendent will notify the respondent of the right to request a hearing in accordance with ORS 183.415.

(a) The hearing request must be made to the Superintendent within 30 days of receiving notice;

(b) The Superintendent will appoint a hearings officer who will conduct the hearing in accordance with ORS 183.413 to 183.470;

(c) The burden of proof at the hearing is on the Department;

(d) The Superintendent's decision is final, subject to appeal to the United States Secretary of Education or the Oregon Court of Appeals.

(19) No person may be subject to retaliation or discrimination for having filed or participated in this complaint procedure. Any person who believes that she or he has been subject to retaliation or discrimination may file a complaint under this rule with the Superintendent.

Stat. Auth.: ORS 343.041

Stats. Implemented: ORS 343.041, 34 CFR 300.151-153; 34 CFR 300.504(a)(2)
Hist.: 1EB 28-1980, f. & ef. 12-23-80; EB 26-1987(Temp), f. & ef. 11-17-87; EB 22-1988, f. & cert. ef. 5-24-88; EB 32-1988, f. & cert. ef. 8-3-88; EB 44-1990, f. & cert. ef. 9-12-90; EB 35-1992(Temp), f. & cert. ef. 11-24-92; EB 8-1993, f. & cert. ef. 3-25-93; ODE 15-1999, f. & cert. ef. 9-24-99, Renumbered from 581-001-0010; ODE 29-2000, f. & cert. ef. 12-11-00; ODE 2-2003, f. & cert. ef. 3-10-03; Renumbered from 581-015-0054, ODE 10-2007, f. & cert. ef. 4-25-07; ODE 6-2011, f. & cert. ef. 4-22-11; ODE 9-2013(Temp), f. & cert. ef. 4-9-13 thru 10-6-13; ODE 14-2013, f. & cert. ef. 7-11-13

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Oregon Health Authority, Division of Medical Assistance Programs
Chapter 410

Rule Caption: Change in Clozaril Monitoring coding and re-write rule for clarity
Adm. Order No.: DMAP 26-2013
Filed with Sec. of State: 6-25-2013
Certified to be Effective: 6-25-13
Notice Publication Date: 6-1-2013
Rules Amended: 410-121-0190
Subject: The Pharmaceutical Services Program administrative rules (division 121) govern Division payments for services provided to certain clients. The Division temporarily amended 410-121-0190 for clarity.

410-121-0190 Rule re-written to clarify Clozaril Management Monitoring and Medication Therapy Management Services billing
Rules Coordinator: Cheryl Peters—(503) 945-6527

410-121-0190
Medication Therapy Management Services and Clozapine Therapy Monitoring

(1) Clozapine monitoring protocol requires enhanced record keeping and reporting to the drug manufacturer's registry in order to dispense the medication. Dispensing pharmacy must meet all drug manufacturers requirements including data reporting.

(2) Clozapine monitoring includes documentation of client's diagnosis, dosage, dosage changes, appropriate laboratory reports (e.g. white blood cell counts), evaluation intervals, and submission of appropriate information to drug manufacturer to allow dispensing of medication;

(3) Clozapine monitoring is to be billed using appropriate Medication Therapy Management Services (MTMS) Current Procedural Terminology (CPT) code with the modifier TC appended. This is limited to no more than 5 units in 30 day time period per client, including the 30 day period from the date of discontinuation of clozapine therapy;

(4) Clozapine monitoring must be billed by a pharmacy;

(5) MTMS rendered outside of clozapine management must be performed by a licensed pharmacist and must be billed to appropriately reflect the performing provider. These encounters must be billed using the appropriate MTMS CPT code without the TC modifier.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; HR 6-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 17-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 45-2002, f. & cert. ef. 10-1-02; OMAP 20-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 9-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 61-2005, f. 11-29-05, cert. ef. 12-1-05; DMAP 44-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 59-2012(Temp), f. 12-27-12, cert. ef. 12-28-12 thru 6-25-13; DMAP 26-2013, f. & cert. ef. 6-25-13

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Rule Caption: Align with other rules referenced; establish clarity, and change in coding for pharmacy clozaril monitoring
Adm. Order No.: DMAP 27-2013
Filed with Sec. of State: 6-25-2013
Certified to be Effective: 6-25-13
Notice Publication Date: 6-1-2013
Rules Amended: 410-130-0180, 410-130-0240
Subject: The Medical Surgical Program administrative rules (Division 130) govern Division payments for services provided to certain clients. The Division needs to amend rules as follows:

410-130-0180 Rule amended to update clozaril monitoring and outline Division's response to changes in national code set requirements.

410-130-0240 Rule re-written to align with other OHP rules and provide more clarity on medical services.
Rules Coordinator: Cheryl Peters—(503) 945-6527

410-130-0180
Drugs

(1) The Division of Medical Assistance Programs' (Division) Medical-Surgical Services Program reimburses practitioners for drugs only when administered by the practitioner in the office, clinic or home settings. The Division does not reimburse practitioners for drugs that are self-administered by the client, except for contraceptives such as birth control pills, spermicides and patches:

(a) Use an appropriate Current Procedural Terminology (CPT) therapeutic injection code for administration of injectables;

(b) Use an appropriate Healthcare Common Procedure Coding System (HCPCS) code for the specific drug. Do not bill for drugs under code 99070; The Division requires both the NDC number and HCPCS codes on all claim forms.

(c) When there is no specific HCPCS code for a drug or biological, use an appropriate unlisted code from the list below and bill at acquisition cost (purchase price plus postage):

(A) J3490;
(B) J3590;
(C) J7599;
(D) J7699;
(E) J7799;
(F) J8499;
(G) J8999;
(H) J9999;

(I) Include the name of the drug, National Drug Code (NDC) number and dosage.

(2) Do not bill for local anesthetics; reimbursement is included in the payment for the tray and/or procedure.

(3) For codes requiring prior authorization and codes that are Not Covered/Bundled, refer to OAR 410-130-0200 Table 130-0200-1 and OAR 410-130-0220 Table 130-0220-1.

(4) Not covered services and supplies include:

(a) Laetrile;

(b) Home pregnancy kits and products designed to promote fertility;

(c) Dimethyl sulfoxide (DMSO), except for instillation into the urinary bladder for symptomatic relief of interstitial cystitis;

(d) Infertility drugs;

(e) Sodium hyaluronate and Synvisc.

(5) Follow criteria outlined in the following:

(a) Billing Requirements — OAR 410-121-0150;

(b) Brand Name Pharmaceuticals — OAR 410-121-0155;

(c) Prior Authorization Procedures — OAR 410-121-0060;

(d) Drugs and Products Requiring Prior Authorization — OAR 410-121-0040;

(e) Drug Use Review — OAR 410-121-0100;

(f) Participation in Medicaid's Drug Rebate Program — OAR 410-121-0157.

(A) The Division cannot reimburse providers for a drug unless the drug manufacturer has signed an agreement with the Centers for Medicare and Medicaid Services (CMS) to participate in the Medicaid Drug Rebate Program.

(B) To verify that a drug manufacturer participates in the Medicaid Drug Rebate Program, visit the CMS website below to verify that the first five digits of the NDC number (labeler code) are listed as a participating drug company:http://www.cms.hhs.gov/MedicaidDrugRebateProgram/10_DrugComContactInfo.asp

(6) Clozaril/Clozapine therapy:

(a) Clozapine is covered only for the treatment of clients who have failed therapy with at least two anti-psychotic medications;

(b) Clozapine supervision is the management and record keeping of clozapine dispensing as required by the manufacturer of clozapine. This is part of an evaluation and management service conducted by the appropriately licensed prescribing medical practitioner;

(c) Pharmacies dispensing clozapine shall comply with OAR 410-121-0190.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0620; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 43-1991, f. & cert. ef. 10-1-91; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 10-1996, f. 5-31-96, cert. ef. 6-1-96; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 2-2002, f. 2-15-02, cert. ef. 4-1-02; OMAP 33-2002, f. & cert. ef. 8-1-02; OMAP 39-2002, f. 9-13-02, cert. ef. 9-15-02; OMAP 52-2002, f. & cert. ef. 10-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-

1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 5-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 20-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 18-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 58-2012(Temp), f. 12-27-12, cert. ef. 12-28-12 thru 6-25-13; DMAP 27-2013, f. & cert. ef. 6-25-13

410-130-0240
Medical Services

(1) Coverage of medical and surgical services are subject to the Health Evidence Review Commission's List of Prioritized Services. Medical and surgical services requiring prior authorization (PA) are listed in OAR 410-130-0200, PA Table 130-0200-1, and medical and surgical services that are Not Covered/Bundled services are listed in OAR 410-130-0220, Table 130-0220-1.

(2) Coverage for acupuncture:

(a) Oregon Health Plan Standard benefit package covers acupuncture services only for chemical dependency;

(b) Oregon Health Plan Plus benefit package covers acupuncture services according to the HERC List of Prioritized Services.

(3) Coverage for chiropractic services provided by an enrolled chiropractor are subject to the HERC List of Prioritized Services, and benefit plan for:

(a) Diagnostic visits, including evaluation and management services;

(b) Chiropractic manipulative treatment;

(c) Laboratory and radiology services.

(4) Maternity care and delivery:

(a) The Division may consider payment for delivery within a clinic, birthing center or home setting;

(b) Within the home setting the Division may consider payment for appropriate supplies in addition to delivery payment. The additional payment for supplies includes all supplies, equipment, staff assistance, new born screening cards, and local/topical anesthetics;

(c) Division may consider payment for physician administered medications associated with delivery except for local/topical anesthetics;

(d) When labor management conducted by a LDEM does not result in a delivery and client is appropriately transferred the provider shall code for labor management only. Bill 59899 and attach a report;

(e) For multiple births, use the appropriate CPT code for the first vaginal or cesarean delivery that includes antepartum and postpartum care, and the subsequent births under the respective delivery only code.

(For example, for total obstetrical care with cesarean delivery of twins, bill 59510 for the first delivery and 59514 for the second delivery.)

(5) Neonatal Intensive Care Unit (NICU) procedures:

(a) Are reimbursed only to neonatologists and pediatric intensivists for services provided to infants when admitted to a Neonatal or Pediatric Intensive Care Unit (NICU/PICU). All other pediatricians must use other CPT codes when billing for services provided to neonates and infants;

(b) Neonatal intensive care codes are not payable for infants on Extracorporeal Membrane Oxygenation (ECMO). Use appropriate CPT ECMO codes.

(6) Neurology/Neuromuscular — Payment for polysomnograms and multiple sleep latency tests (MSLT) are each limited to two in a 12 month period.

(7) Oral Health Services provided by medical practitioners may include an oral assessment and application of topical fluoride varnish during a medical visit to children under the age of 7 years. Refer to Dental Services rule 410-123-1260.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

Hist.: PWC 839(Temp), f. & ef. 4-28-77; PWC 849, f. 7-15-77, ef. 8-1-77; PWC 868, f. 12-30-77, ef. 2-1-78; AFS 14-1978(Temp), f. 4-14-78, ef. 4-15-78; AFS 31-1978, f. & ef. 8-1-78; AFS 26-1980, f. 5-21-80, ef. 6-1-80, AFS 56-1980(Temp), f. 8-29-80, ef. 9-1-80; AFS 2-1981, f. 1-9-81, ef. 2-1-81; AFS 36-1981, f. 6-29-81, ef. 7-1-81; AFS 27-1982, f. 4-22-82 & AFS 51-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 38-1983, f. & ef. 8-1-83; AFS 57-1983, f. 11-29-83, ef. 1-1-84; AFS 48-1984(Temp), f. 11-30-84, ef. 12-1-84; AFS 29-1985, f. 5-22-85, ef. 5-29-85; AFS 50-1986, f. 6-30-86, ef. 8-1-86; AFS 56-1987, f. 10-29-87, ef. 11-1-87; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; AFS 48-1989, f. & cert. ef. 8-24-89, Renumbered from 461-014-0021 & 461-014-0056; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0650, 461-014-0690 & 461-014-0700; HR 14-1991(Temp), f. & cert. ef. 3-7-91; HR 18-1991(Temp), f. 4-12-91, cert. ef. 4-15-91; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 24-1991, f. & cert. ef. 6-18-91; HR 2-1992, f. & cert. ef. 1-2-92; HR 8-1992, f. 2-28-92, cert. ef. 3-1-92; HR 18-1992, f. & cert. ef. 7-1-92; HR 36-1992, f. & cert. ef. 12-1-92; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 16-1993, f. & cert. ef. 7-2-93; HR 6-1994, f. & cert. ef. 2-1-94, Renumbered from 410-130-0320, 410-130-0340, 410-130-0360 & 410-130-0740; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 10-1996, f. 5-31-96, cert. ef. 6-1-96; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 88-2004, f. 11-24-04, cert. ef. 12-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 18-2009, f. 6-12-09, cert. ef. 7-1-09; DMAP 58-2012(Temp), f. 12-27-12, cert. ef. 12-28-12 thru 6-25-13; DMAP 27-2013, f. & cert. ef. 6-25-13

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Rule Caption: Add Coordinated Care Organization (CCO) language for dental integration
Adm. Order No.: DMAP 28-2013(Temp)
Filed with Sec. of State: 6-26-2013
Certified to be Effective: 7-1-13 thru 12-28-13
Notice Publication Date:
Rules Amended: 410-123-1160, 410-123-1260, 410-123-1490, 410-123-1600
Subject: The Division needs to amend these rules to incorporate necessary language related to dental services being under the responsibility of the Coordinated Care Organizations (CCO). Minor changes have been made for clarity of rule language.
Rules Coordinator: Cheryl Peters—(503) 945-6527

410-123-1160
Prior Authorization (PA)

(1) Division of Medical Assistance Programs (Division) prior authorization (PA) requirements:

(a) For fee-for-service (FFS) dental clients, the following services require PA:

(A) Crowns (porcelain fused to metal);

(B) Crown repair;

(C) Retreatment of previous root canal therapy — anterior;

(D) Complete dentures;

(E) Immediate dentures;

(F) Partial dentures;

(G) Prefabricated post and core in addition to fixed partial denture retainer;

(H) Fixed partial denture repairs;

(I) Skin graft; and

(J) Orthodontics (when covered pursuant to OAR 410-123-1260);

(b) Hospital dentistry always requires PA, regardless of the client's enrollment status. Refer to OAR 410-123-1490 for more information;

(c) Oral surgical services require PA when performed in an ambulatory surgical center (ASC) or an outpatient or inpatient hospital setting and related anesthesia. Refer to OAR 410-123-1260 (Oral Surgery Services), and the current Medical Surgical Services administrative rule 410-130-0200 for information;

(d) Maxillofacial surgeries may require PA in some instances. Refer to the current Medical Surgical Services administrative rule 410-130-0200, for information.

(2) The Division does not require PA for outpatient or inpatient services related to life-threatening emergencies. The client's clinical record must document any appropriate clinical information that supports the need for the hospitalization.

(3) Information and instructions for requesting PA may be found in the Division's Dental Services Provider Guide at http://www.dhs.state.or.us/policy/healthplan/guides/dental/main.html:

(a) PA's must be submitted to the Division in writing. The Division shall not accept telephone calls requesting PA;

(b) The Division may request the treating dentist to submit appropriate radiographs or other clinical information that justifies the treatment:

(A) When radiographs are required they must be:

(i) Readable copies;

(ii) Mounted or loose;

(iii) In an envelope, stapled to the PA form;

(iv) Clearly labeled with the dentist's name and address and the client's name; and

(v) If digital x-ray, they must be of photo quality;

(B) Providers may not submit radiographs unless it is required by these rules or upon the Division's request.

(4) The Division shall issue a decision on PA requests within 30 days of receipt of the request. The Division shall provide PA for services when:

(a) The prognosis is favorable;

(b) The treatment is practical;

(c) The services are dentally appropriate; and

(d) A lesser-cost procedure would not achieve the same ultimate results.

(5) PA does not guarantee eligibility or reimbursement. Providers must check the client's eligibility on the date of service.

(6) For certain services and billings, the Division shall seek a general practice consultant or an oral surgery consultant for professional review to determine if a PA may be approved. The Division shall deny PA if the consultant decides that the clinical information furnished does not support the treatment of services.

(7) For coordinated care or managed care PA requirements:

(a) For services other than hospital dentistry, contact the client's Dental Care Organization (DCO), or Coordinated Care Organization (CCO) if the CCO provides for dental services, for PA requirements for individual services and supplies listed in the Dental Services administrative rules. DCOs and CCOs may have different PA requirements for dental services than those listed in this administrative rule;

(b) PA requirements for hospital dentistry are covered in OAR 410-123-1490(f).

Stat. Auth.: ORS 413.042, 414.065 & 414.071
Stats. Implemented: ORS 414.065
Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 32-1994, f. & cert. ef. 11-1-94; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 16-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 41-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 14-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 13-2013, f. 3-27-13, cert. ef. 4-1-13; DMAP 28-2013(Temp), f. 6-26-13, cert. ef. 7-1-13 thru 12-28-13

410-123-1260
OHP Plus Dental Benefits

(1) GENERAL:

(a) Early and Periodic Screening, Diagnosis and Treatment (EPSDT):

(A) Refer to Code of Federal Regulations (42 CFR 441, Subpart B) and OAR chapter 410, division 120 for definitions of the EPSDT program, eligible clients, and related services. EPSDT dental services includes, but are not limited to:

(i) Dental screening services for eligible EPSDT individuals; and

(ii) Dental diagnosis and treatment which is indicated by screening, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health;

(B) Providers must provide EPSDT services for eligible Division clients according to the following documents:

(i) The Dental Services Program administrative rules (OAR chapter 410, division 123), for dentally appropriate services funded on the Oregon Health Evidence Review Commission Prioritized List of Health Services (Prioritized List); and

(ii) The "Oregon Health Plan (OHP) — Recommended Dental Periodicity Schedule," dated January 1, 2010, incorporated by reference and posted on the Division Web site in the Dental Services Provider Guide document at www.oha.state.or.us/policy/healthplan/guides/dental/main.html;

(b) Restorative, periodontal and prosthetic treatments:

(A) Treatments must be consistent with the prevailing standard of care, documentation must be included in the client's charts to support the treatment, and may be limited as follows:

(i) When prognosis is unfavorable;

(ii) When treatment is impractical;

(iii) A lesser-cost procedure would achieve the same ultimate result; or

(iv) The treatment has specific limitations outlined in this rule;

(B) Prosthetic treatment, including porcelain fused to metal crowns, are limited until rampant progression of caries is arrested and a period of adequate oral hygiene and periodontal stability is demonstrated; periodontal health needs to be stable and supportive of a prosthetic.

(2) DIAGNOSTIC SERVICES:

(a) Exams:

(A) For children (under 19 years of age):

(i) The Division shall reimburse exams (billed as D0120, D0145, D0150, or D0180) a maximum of twice every 12 months with the following limitations:

(I) D0150: once every 12 months when performed by the same practitioner;

(II) D0150: twice every 12 months only when performed by different practitioners;

(III) D0180: once every 12 months;

(ii) The Division shall reimburse D0160 only once every 12 months when performed by the same practitioner;

(B) For adults (19 years of age and older) – The Division shall reimburse exams (billed as D0120, D0150, D0160, or D0180) once every 12 months;

(C) For problem focused exams (urgent or emergent problems), the Division shall reimburse D0140 for the initial exam. The Division shall reimburse D0170 for related problem focused follow-up exams. Providers should not bill D0140 and D0170 for routine dental visits;

(D) The Division only covers oral exams by medical practitioners when the medical practitioner is an oral surgeon;

(E) As the American Dental Association's Current Dental Terminology (CDT) codebook specifies the evaluation, diagnosis and treatment planning components of the exam are the responsibility of the dentist, the Division may not reimburse dental exams when furnished by a dental hygienist (with or without an expanded practice permit);

(b) Assessments of a patient (D0191):

(A) When performed by a dental practitioner, the Division shall reimburse:

(i) If performed by a dentist outside of a dental office;

(ii) If performed by a dental hygienist with an expanded practice dental hygiene permit;

(iii) Only if an exam (D0120-D0180) is not performed on the same date of service. An oral assessment is included in the exam;

(iii) For children (under 19 years of age), a maximum of twice every 12 months; and

(iv) For adults (age 19 and older), a maximum of once every 12 months;

(B) When performed by a medical practitioner, the Division shall cover:

(i) Only for children under 7 years of age; and

(ii) A maximum of once a year;

(C) Medical practitioners performing D0191 shall bill the client's medical coverage for reimbursement (Coordinated Care Organization (CCO) or Prepaid Health Plan (PHP) if enrolled member, or Division if fee-for-service);

(D) The maximum limits for this procedure for dental practitioners do not affect the maximum limits for medical providers, and vice versa; and

(E) An assessment does not take the place of the need for oral evaluations/exams;

(c) Radiographs:

(A) The Division shall reimburse for routine radiographs once every 12 months;

(B) The Division shall reimburse bitewing radiographs for routine screening once every 12 months;

(C) The Division shall reimburse a maximum of six radiographs for any one emergency;

(D) For clients under age six, radiographs may be billed separately every 12 months as follows:

(i) D0220 — once;

(ii) D0230 — a maximum of five times;

(iii) D0270 — a maximum of twice, or D0272 once;

(E) The Division shall reimburse for panoramic (D0330) or intra-oral complete series (D0210) once every five years, but both cannot be done within the five-year period;

(F) Clients must be a minimum of six years old for billing intra-oral complete series (D0210). The minimum standards for reimbursement of intra-oral complete series are:

(i) For clients age six through 11- a minimum of 10 periapicals and two bitewings for a total of 12 films;

(ii) For clients ages 12 and older - a minimum of 10 periapicals and four bitewings for a total of 14 films;

(G) If fees for multiple single radiographs exceed the allowable reimbursement for a full mouth complete series (D0210), the Division shall reimburse for the complete series;

(H) Additional films may be covered if dentally or medically appropriate, e.g., fractures (Refer to OAR 410-123-1060 and 410-120-0000);

(I) If the Division determines the number of radiographs to be excessive, payment for some or all radiographs of the same tooth or area may be denied;

(J) The exception to these limitations is if the client is new to the office or clinic and the office or clinic was unsuccessful in obtaining radiographs from the previous dental office or clinic. Supporting documentation outlining the provider's attempts to receive previous records must be included in the client's records;

(K) Digital radiographs, if printed, should be on photo paper to assure sufficient quality of images.

(3) PREVENTIVE SERVICES:

(a) Prophylaxis:

(A) For children (under 19 years of age) — Limited to twice per 12 months;

(B) For adults (19 years of age and older) — Limited to once per 12 months;

(C) Additional prophylaxis benefit provisions may be available for persons with high risk oral conditions due to disease process, pregnancy, medications or other medical treatments or conditions, severe periodontal disease, rampant caries and/or for persons with disabilities who cannot perform adequate daily oral health care;

(D) Are coded using the appropriate Current Dental Terminology (CDT) coding:

(i) D1110 (Prophylaxis — Adult) — Use for clients 14 years of age and older; and

(ii) D1120 (Prophylaxis — Child) — Use for clients under 14 years of age;

(b) Topical fluoride treatment:

(A) For adults (19 years of age and older) — Limited to once every 12 months;

(B) For children (under 19 years of age) — Limited to twice every 12 months;

(C) For children under 7 years of age, topical fluoride varnish may be applied by a medical practitioner during a medical visit:

(i) Bill the Division directly regardless of whether the client is fee-for-service (FFS) or enrolled in a CCO or a PHP;

(ii) Bill using a professional claim format with the appropriate CDT code (D1206 — Topical Fluoride Varnish);

(D) Additional topical fluoride treatments may be available, up to a total of 4 treatments per client within a 12-month period, when high-risk conditions or oral health factors are clearly documented in chart notes for the following clients who:

(i) Have high-risk oral conditions due to disease process, medications, other medical treatments or conditions, or rampant caries;

(ii) Are pregnant;

(iii) Have physical disabilities and cannot perform adequate, daily oral health care;

(iv) Have a developmental disability or other severe cognitive impairment that cannot perform adequate, daily oral health care; or

(v) Are under seven year old with high-risk oral health factors, such as poor oral hygiene, deep pits and fissures (grooves) in teeth, severely crowded teeth, poor diet, etc;

(E) Flouride limits include any combination of fluoride varnish (D1206) or other topical fluoride (D1208);

(c) Sealants (D1351):

(A) Are covered only for children under 16 years of age;

(B) The Division limits coverage to:

(i) Permanent molars; and

(ii) Only one sealant treatment per molar every five years, except for visible evidence of clinical failure;

(d) Tobacco cessation:

(A) For services provided during a dental visit, bill as a dental service using CDT code D1320 when the following brief counseling is provided:

(i) Ask patients about their tobacco-use status at each visit and record information in the chart;

(ii) Advise patients on their oral health conditions related to tobacco use and give direct advice to quit using tobacco and a strong personalized message to seek help; and

(iii) Refer patients who are ready to quit, utilizing internal and external resources to complete the remaining three A's (assess, assist, arrange) of the standard intervention protocol for tobacco;

(B) The Division allows a maximum of 10 services within a three-month period;

(C) For tobacco cessation services provided during a medical visit follow criteria outlined in OAR 410-130-0190;

(e) Space management:

(A) The Division shall cover fixed and removable space maintainers (D1510, D1515, D1520, and D1525) only for clients under 19 years of age;

(B) The Division may not reimburse for replacement of lost or damaged removable space maintainers.

(4) RESTORATIVE SERVICES:

(a) Restorations — amalgam and composite:

(A) The Division shall cover resin-based composite restorations only for anterior teeth (D2330-D2390) and one surface posterior teeth (D2391);

(B) Resin-based composite crowns on anterior teeth (D2390) are only covered for clients under 21 years of age or who are pregnant;

(C) The Division reimburses posterior composite restorations at the same rate as amalgam restorations;

(D) The Division limits payment for replacement of posterior composite restorations to once every five years;

(D) The Division limits payment of covered restorations to the maximum restoration fee of four surfaces per tooth. Refer to the American Dental Association (ADA) CDT codebook for definitions of restorative procedures;

(E) Providers must combine and bill multiple surface restorations as one line per tooth using the appropriate code. Providers may not bill multiple surface restorations performed on a single tooth on the same day on separate lines. For example, if tooth #30 has a buccal amalgam and a mesial-occlusal-distal (MOD) amalgam, then bill MOD, B, using code D2161 (four or more surfaces);

(F) The Division may not reimburse for an amalgam or composite restoration and a crown on the same tooth;

(G) The Division reimburses for a surface once in each treatment episode regardless of the number or combination of restorations;

(H) The restoration fee includes payment for occlusal adjustment and polishing of the restoration;

(b) Crowns and related services:

(A) General payment policies:

(i) The fee for the crown includes payment for preparation of the gingival tissue;

(ii) The Division shall cover crowns only when:

(I) There is significant loss of clinical crown and no other restoration will restore function; and

(II) The crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures;

(iii) The Division shall cover core buildup (D2950) only when necessary to retain a cast restoration due to extensive loss of tooth structure from caries or a fracture and only when done in conjunction with a crown. Less than 50% of the tooth structure must be remaining for coverage of the core buildup. The Division may not cover core buildup if the crown is not covered under the client's OHP benefit package;

(iv) Reimbursement of retention pins (D2951) is per tooth, not per pin;

(B) The Division shall not cover the following services:

(i) Endodontic therapy alone (with or without a post);

(ii) Aesthetics (cosmetics);

(iii) Crowns in cases of advanced periodontal disease or when a poor crown/root ratio exists for any reason;

(C) The Division shall cover acrylic heat or light cured crowns (D2970 temporary crown, fractured tooth) — allowed only for anterior permanent teeth;

(D) The Division shall cover the following only for clients under 21 years of age or who are pregnant:

(i) Prefabricated plastic crowns (D2932) — allowed only for anterior teeth, permanent or primary;

(ii) Stainless steel crowns (D2930/D2931) — allowed only for anterior primary teeth and posterior permanent or primary teeth;

(iii) Prefabricated stainless steel crowns with resin window (D2933) — allowed only for anterior teeth, permanent or primary;

(iv) Prefabricated post and core in addition to crowns (D2954/D2957);

(v) Permanent crowns (resin-based composite — D2710 and D2712, and porcelain fused to metal (PFM) — D2751 and D2752) as follows:

(I) Limited to teeth numbers 6–11, 22 and 27 only, if dentally appropriate;

(II) Limited to four in a seven-year period. This limitation includes any replacement crowns allowed according to (E)(i) of this rule;

(III) Only for clients at least 16 years of age; and

(IV) Rampant caries are arrested and the client demonstrates a period of oral hygiene before prosthetics are proposed;

(vi) PFM crowns (D2751 and D2752) must also meet the following additional criteria:

(I) The dental practitioner has attempted all other dentally appropriate restoration options, and documented failure of those options;

(II) Written documentation in the client's chart indicates that PFM is the only restoration option that will restore function;

(III) The dental practitioner submits radiographs to the Division for review; history, diagnosis, and treatment plan may be requested. See OAR 410123-1100 (Services Reviewed by the Division of Medical Assistance Programs);

(IV) The client has documented stable periodontal status with pocket depths within 1–3 millimeters. If PFM crowns are placed with pocket depths of 4 millimeter and over, documentation must be maintained in the

client's chart of the dentist's findings supporting stability and why the increased pocket depths will not adversely affect expected long term prognosis;

(V) The crown has a favorable long-term prognosis; and

(VI) If tooth to be crowned is clasp/abutment tooth in partial denture, both prognosis for crown itself and tooth's contribution to partial denture must have favorable expected long-term prognosis;

(E) Crown replacement:

(i) Permanent crown replacement limited to once every seven years;

(ii) All other crown replacement limited to once every five years; and

(iii) The Division may make exceptions to crown replacement limitations due to acute trauma, based on the following factors:

(I) Extent of crown damage;

(II) Extent of damage to other teeth or crowns;

(III) Extent of impaired mastication;

(IV) Tooth is restorable without other surgical procedures; and

(V) If loss of tooth would result in coverage of removable prosthetic;

(F) Crown repair (D2980) is limited to only anterior teeth.

(5) ENDODONTIC SERVICES:

(a) Pulp capping:

(A) The Division includes direct and indirect pulp caps in the restoration fee; no additional payment shall be made for clients with the OHP Plus benefit package;

(B) The Division covers direct pulp caps as a separate service for clients with the OHP Standard benefit package because restorations are not a covered benefit under this benefit package;

(b) Endodontic therapy:

(A) Pulpal therapy on primary teeth (D3230 and D3240) is covered only for clients under 21 years of age;

(B) For permanent teeth:

(i) Anterior and bicuspid endodontic therapy (D3310 and D3320) is covered for all OHP Plus clients; and

(ii) Molar endodontic therapy (D3330):

(I) For clients through age 20, is covered only for first and second molars; and

(II) For clients age 21 and older who are pregnant, is covered only for first molars;

(C) The Division covers endodontics only if the crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures;

(c) Endodontic retreatment and apicoectomy/periradicular surgery:

(A) The Division does not cover retreatment of a previous root canal or apicoectomy/periradicular surgery for bicuspid or molars;

(B) The Division limits either a retreatment or an apicoectomy (but not both procedures for the same tooth) to symptomatic anterior teeth when:

(i) Crown-to-root ratio is 50:50 or better;

(ii) The tooth is restorable without other surgical procedures; or

(iii) If loss of tooth would result in the need for removable prosthodontics;

(C) Retrograde filling (D3430) is covered only when done in conjunction with a covered apicoectomy of an anterior tooth;

(d) The Division does not allow separate reimbursement for open-and-drain as a palliative procedure when the root canal is completed on the same date of service, or if the same practitioner or dental practitioner in the same group practice completed the procedure;

(e) The Division covers endodontics if the tooth is restorable within the OHP benefit coverage package;

(f) Apexification/recalcification and pulpal regeneration procedures:

(A) The Division limits payment for apexification to a maximum of five treatments on permanent teeth only;

(B) Apexification/recalcification and pulpal regeneration procedures are covered only for clients under 21 years of age or who are pregnant.

(6) PERIODONTIC SERVICES:

(a) Surgical periodontal services:

(A) Gingivectomy/Gingivoplasty (D4210 and D4211) — limited to coverage for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to oral hygiene procedures, e.g., Dilantin hyperplasia; and

(B) Includes six months routine postoperative care;

(C) The Division shall consider gingivectomy or gingivolplasty to allow for access for restorative procedure, per tooth (D4212) as part of the restoration and will not provide a separate reimbursement for this procedure;

(b) Non-surgical periodontal services:

(A) Periodontal scaling and root planing (D4341 and D4342):

(i) For clients through age 20, allowed once every two years;

(ii) For clients age 21 and over, allowed once every three years;

(iii) A maximum of two quadrants on one date of service is payable, except in extraordinary circumstances;

(iv) Quadrants are not limited to physical area, but are further defined by the number of teeth with pockets 5 mm or greater:

(I) D4341 is allowed for quadrants with at least four or more teeth with pockets 5 mm or greater;

(II) D4342 is allowed for quadrants with at least two teeth with pocket depths of 5 mm or greater;

(v) Prior authorization for more frequent scaling and root planing may be requested when:

(I) Medically/dentally necessary due to periodontal disease as defined above is found during pregnancy; and

(II) Client's medical record is submitted that supports the need for increased scaling and root planing;

(B) Full mouth debridement (D4355):

(i) For clients through age 20, allowed only once every 2 years;

(ii) For clients age 21 and older, allowed once every three years;

(c) Periodontal maintenance (D4910):

(A) For clients through age 20, allowed once every six months;

(B) For clients age 21 and older:

(i) Limited to following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three years;

(ii) Allowed once every twelve months;

(iii) Prior authorization for more frequent periodontal maintenance may be requested when:

(I) Medically/dentally necessary, such as due to presence of periodontal disease during pregnancy; and

(II) Client's medical record is submitted that supports the need for increase periodontal maintenance (chart notes, pocket depths and radiographs);

(d) Records must clearly document the clinical indications for all periodontal procedures, including current pocket depth charting and/or radiographs;

(e) The Division may not reimburse for procedures identified by the following codes if performed on the same date of service:

(A) D1110 (Prophylaxis — adult);

(B) D1120 (Prophylaxis — child);

(C) D4210 (Gingivectomy or gingivoplasty — four or more contiguous teeth or bounded teeth spaces per quadrant);

(D) D4211 (Gingivectomy or gingivoplasty — one to three contiguous teeth or bounded teeth spaces per quadrant);

(E) D4341 (Periodontal scaling and root planning — four or more teeth per quadrant);

(F) D4342 (Periodontal scaling and root planning — one to three teeth per quadrant);

(G) D4355 (Full mouth debridement to enable comprehensive evaluation and diagnosis); and

(H) D4910 (Periodontal maintenance).

(7) REMOVABLE PROSTHODONTIC SERVICES:

(a) Clients age 16 years and older are eligible for removable resin base partial dentures (D5211-D5212) and full dentures (complete or immediate, D5110-D5140);

(b) The Division limits full dentures for clients age 21 and older to only those clients who are recently edentulous:

(A) For the purposes of this rule:

(i) "Edentulous" means all teeth removed from the jaw for which the denture is being provided; and

(ii) "Recently edentulous" means the most recent extractions from that jaw occurred within six months of the delivery of the final denture (or, for fabricated prosthetics, the final impression) for that jaw;

(B) See OAR 410-123-1000 for detail regarding billing fabricated prosthetics;

(c) The fee for the partial and full dentures includes payment for adjustments during the six-month period following delivery to clients;

(d) Resin partial dentures (D5211-D5212):

(A) The Division may not approve resin partial dentures if stainless steel crowns are used as abutments;

(B) For clients through age 20, the client must have one or more anterior teeth missing or four or more missing posterior teeth per arch with resulting space equivalent to that loss demonstrating inability to masticate. Third molars are not a consideration when counting missing teeth;

(C) For clients age 21 and older, the client must have one or more missing anterior teeth or six or more missing posterior teeth per arch with

documentation by the provider of resulting space causing serious impairment to mastification. Third molars are not a consideration when counting missing teeth;

(D) The dental practitioner must note the teeth to be replaced and teeth to be clasped when requesting prior authorization (PA);

(e) Replacement of removable partial or full dentures, when it cannot be made clinically serviceable by a less costly procedure (e.g., reline, rebase, repair, tooth replacement), is limited to the following:

(A) For clients at least 16 years and under 21 years of age - the Division shall replace full or partial dentures once every ten years, only if dentally appropriate. This does not imply that replacement of dentures or partials must be done once every ten years, but only when dentally appropriate;

(B) For clients 21 years of age and older - the Division may not cover replacement of full dentures, but shall cover replacement of partial dentures once every 10 years only if dentally appropriate;

(C) The ten year limitations apply to the client regardless of the client's OHP or Dental Care Organization (DCO)/Coordinated Care Organization (CCO) enrollment status at the time client's last denture or partial was received. For example: a client receives a partial on February 1, 2002, and becomes a FFS OHP client in 2005. The client is not eligible for a replacement partial until February 1, 2012. The client gets a replacement partial on February 3, 2012 while FFS and a year later enrolls in a DCO, CCO. The client would not be eligible for another partial until February 3, 2022, regardless of DCO, CCO or FFS enrollment;

(D) Replacement of partial dentures with full dentures is payable ten years after the partial denture placement. Exceptions to this limitation may be made in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical and/or medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene may not warrant replacement;

(f) The Division limits reimbursement of adjustments and repairs of dentures that are needed beyond six months after delivery of the denture as follows for clients 21 years of age and older:

(A) A maximum of 4 times per year for:

(i) Adjusting complete and partial dentures, per arch (D5410-D5422);

(ii) Replacing missing or broken teeth on a complete denture – each tooth (D5520);

(iii) Replacing broken tooth on a partial denture – each tooth (D5640);

(iv) Adding tooth to existing partial denture (D5650);

(B) A maximum of 2 times per year for:

(i) Repairing broken complete denture base (D5510);

(ii) Repairing partial resin denture base (D5610);

(iii) Repairing partial cast framework (D5620);

(iv) Repairing or replacing broken clasp (D5630);

(v) Adding clasp to existing partial denture (D5660);

(g) Replacement of all teeth and acrylic on cast metal framework (D5670D5671):

(A) Is covered for clients age 16 and older a maximum of once every 10 years, per arch;

(B) Ten years or more must have passed since the original partial denture was delivered;

(C) Is considered replacement of the partial so a new partial denture may not be reimbursed for another 10 years; and

(D) Requires prior authorization as it is considered a replacement partial denture;

(h) Denture rebase procedures:

(A) The Division shall cover rebases only if a reline may not adequately solve the problem;

(B) For clients through age 20, the Division limits payment for rebase to once every three years;

(C) For clients age 21 and older:

(i) There must be documentation of a current reline which has been done and failed; and

(ii) The Division limits payment for rebase to once every five years;

(D) The Division may make exceptions to this limitation in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical and medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene may not warrant rebasing;

(i) Denture reline procedures:

(A) For clients through age 20, the Division limits payment for reline of complete or partial dentures to once every three years;

(B) For clients age 21 and older, the Division limits payment for reline of complete or partial dentures to once every five years;

(C) The Division may make exceptions to this limitation under the same conditions warranting replacement;

(D) Laboratory relines:

(i) Are not payable prior to six months after placement of an immediate denture; and

(ii) For clients through age 20, are limited to once every three years;

(iii) For clients age 21 and older, are limited to once every five years;

(j) Interim partial dentures (D5820-D5821, also referred to as "flippers"):

(A) Are allowed if the client has one or more anterior teeth missing; and

(B) The Division shall reimburse for replacement of interim partial dentures once every 5 years, but only when dentally appropriate;

(k) Tissue conditioning:

(A) Is allowed once per denture unit in conjunction with immediate dentures; and

(B) Is allowed once prior to new prosthetic placement.

(8) MAXILLOFACIAL PROSTHETIC SERVICES:

(a) Fluoride gel carrier (D5986) is limited to those patients whose severity of oral disease causes the increased cleaning and fluoride treatments allowed in rule to be insufficient. The dental practitioner must document failure of those options prior to use of the fluoride gel carrier;

(b) All other maxillofacial prosthetics (D5900-D5999) are medical services. Refer to the "Covered and Non-Covered Dental Services" document and OAR 410-123-1220:

(A) Bill for medical maxillofacial prosthetics using the professional (CMS1500, DMAP 505 or 837P) claim format:

(B) For clients receiving services through a CCO or PHP, bill medical maxillofacial prosthetics to the CCO or PHP;

(C) For clients receiving medical services through FFS, bill the Division.

(9) ORAL SURGERY SERVICES:

(a) Bill the following procedures in an accepted dental claim format using CDT codes:

(A) Procedures that are directly related to the teeth and supporting structures that are not due to a medical, including such procedures performed in an ambulatory surgical center (ASC) or an inpatient or outpatient hospital setting;

(B) Services performed in a dental office setting (including an oral surgeon's office):

(i) Such services include, but are not limited to, all dental procedures, local anesthesia, surgical postoperative care, radiographs and follow-up visits;

(ii) Refer to OAR 410-123-1160 for any PA requirements for specific procedures;

(b) Bill the following procedures using the professional claim format and the appropriate American Medical Association (AMA) CPT procedure and ICD9 diagnosis codes:

(A) Procedures that are a result of a medical condition (i.e., fractures, cancer);

(B) Services requiring hospital dentistry that are the result of a medical condition/diagnosis (i.e., fracture, cancer);

(c) Refer to the "Covered and Non-Covered Dental Services" document to see a list of CDT procedure codes on the Prioritized List that may also have CPT medical codes. See OAR 410-123-1220. The procedures listed as "medical" on the table may be covered as medical procedures, and the table may not be all-inclusive of every dental code that has a corresponding medical code;

(d) For clients enrolled in a DCO or CCO responsible for dental services, the DCO, CCO shall pay for those services in the dental plan package;

(e) Oral surgical services performed in an ASC or an inpatient or outpatient hospital setting:

(A) Require PA;

(B) For clients enrolled in a CCO or FCHP, the CCO or FCHP shall pay for the facility charge and anesthesia services. For clients enrolled in a Physician Care Organization (PCO), the PCO shall pay for the outpatient facility charge (including ASCs) and anesthesia.. Refer to the current Medical Surgical Services administrative rules in OAR chapter 410, division 130 for more information;

(C) If a client is enrolled in a CCO or PHP, the provider must contact the CCO or PHP for any required authorization before the service is rendered;

(f) All codes listed as "by report" require an operative report;

(g) The Division covers payment for tooth re-implantation only in cases of traumatic avulsion where there are good indications of success;

(h) Biopsies collected are reimbursed as a dental service. Laboratory services of biopsies are reimbursed as a medical service;

(i) The Division does not cover surgical excisions of soft tissue lesions (D7410-D7415);

(j) Extractions — Includes local anesthesia and routine postoperative care, including treatment of a dry socket if done by the provider of the extraction. Dry socket is not considered a separate service;

(k) Surgical extractions:

(A) Include local anesthesia and routine post-operative care;

(B) The Division limits payment for surgical removal of impacted teeth or removal of residual tooth roots to treatment for only those teeth that have acute infection or abscess, severe tooth pain, and/or unusual swelling of the face or gums;

(C) The Division does not cover alveoloplasty in conjunction with extractions (D7310 and D7311) separately from the extraction;

(D) The Division covers alveoplasty not in conjunction with extractions (D7320-D7321) only for clients under 21 years of age or who are pregnant;

(l) Frenulectomy/frenulotomy (D7960) and frenuloplasty (D7963):

(A) The Division covers either frenulectomy or frenuloplasty once per lifetime per arch only for clients under age 21;

(B) The Division covers maxillary labial frenulectomy only for clients age 12 through 20;

(C) The Division shall cover frenulectomy/frenuloplasty in the following situations:

(i) When the client has ankyloglossia;

(ii) When the condition is deemed to cause gingival recession; or

(iii) When the condition is deemed to cause movement of the gingival margin when the frenum is placed under tension;

(m) The Division covers excision of pericoronal gingival (D7971) only for clients under age 21 or who are pregnant.

(10) ORTHODONTIA SERVICES:

(a) The Division limits orthodontia services and extractions to eligible clients:

(A) With the ICD-9-CM diagnosis of:

(i) Cleft palate; or

(ii) Cleft palate with cleft lip; and

(B) Whose orthodontia treatment began prior to 21 years of age; or

(C) Whose surgical corrections of cleft palate or cleft lip were not completed prior to age 21;

(b) PA is required for orthodontia exams and records. A referral letter from a physician or dentist indicating diagnosis of cleft palate or cleft lip must be included in the client's record and a copy sent with the PA request;

(c) Documentation in the client's record must include diagnosis, length and type of treatment;

(d) Payment for appliance therapy includes the appliance and all follow-up visits;

(e) Orthodontists evaluate orthodontia treatment for cleft palate/cleft lip as two phases. Stage one is generally the use of an activator (palatal expander) and stage two is generally the placement of fixed appliances (banding). The Division shall reimburse each phase separately;

(f) The Division shall pay for orthodontia in one lump sum at the beginning of each phase of treatment. Payment for each phase is for all orthodontia-related services. If the client transfers to another orthodontist during treatment, or treatment is terminated for any reason, the orthodontist must refund to the Division any unused amount of payment, after applying the following formula: Total payment minus $300.00 (for banding) multiplied by the percentage of treatment remaining;

(g) The Division shall use the length of the treatment plan from the original request for authorization to determine the number of treatment months remaining;

(h) As long as the orthodontist continues treatment, the Division may not require a refund even though the client may become ineligible for medical assistance sometime during the treatment period;

(i) Code:

(A) D8660 — PA required (reimbursement for required orthodontia records is included);

(B) Codes D8010-D8690 — PA required.

(11) ADJUNCTIVE GENERAL AND OTHER SERVICES:

(a) Fixed partial denture sectioning (D9120) is covered only when extracting a tooth connected to a fixed prosthesis and a portion of the fixed prosthesis is to remain intact and serviceable, preventing the need for more costly treatment;

(b) Anesthesia:

(A) Only use general anesthesia or IV sedation for those clients with concurrent needs: age, physical, medical or mental status, or degree of difficulty of the procedure (D9220, D9221, D9241 and D9242);

(B) The Division reimburses providers for general anesthesia or IV sedation as follows:

(i) D9220 or D9241: For the first 30 minutes;

(ii) D9221 or D9242: For each additional 15-minute period, up to three hours on the same day of service. Each 15-minute period represents a quantity of one. Enter this number in the quantity column;

(C) The Division reimburses administration of Nitrous Oxide (D9230) per date of service, not by time;

(D) Oral pre-medication anesthesia for conscious sedation (D9248):

(i) Limited to clients under 13 years of age;

(ii) Limited to four times per year;

(iii) Includes payment for monitoring and Nitrous Oxide; and

(iv) Requires use of multiple agents to receive payment;

(E) Upon request, providers must submit a copy of their permit to administer anesthesia, analgesia and sedation to the Division;

(F) For the purpose of Title XIX and Title XXI, the Division limits payment for code D9630 to those oral medications used during a procedure and is not intended for "take home" medication;

(c) The Division limits reimbursement of house/extended care facility call (D9410) only for urgent or emergent dental visits that occur outside of a dental office. This code is not reimbursable for provision of preventive services or for services provided outside of the office for the provider or facilities' convenience;

(d) Oral devices/appliances (E0485, E0486):

(A) These may be placed or fabricated by a dentist or oral surgeon, but are considered a medical service;

(B) Bill the Division, CCO or the PHP for these codes using the professional claim format.

Stat. Auth.: ORS 413.042, 414.065 & 414.707

Stats. Implemented: ORS 414.065 & 414.707

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 20-1995, f. 9-29-95, cert. ef. 10-1-95; OMAP 13-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 28-1998, f. & cert. ef. 9-1-98; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 8-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03; OMAP 55-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 12-2005, f. 3-11-05, cert. ef. 4-1-05; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 18-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 16-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 41-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 14-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 31-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 17-2011, f. & cert. ef. 7-12-11; DMAP 41-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 46-2011, f. 12-23-11, cert. ef. 1-1-12; DMAP 13-2013, f. 3-27-13, cert. ef. 4-1-13; DMAP 28-2013(Temp), f. 6-26-13, cert. ef. 7-1-13 thru 12-28-13

410-123-1490
Hospital Dentistry

(1) The purpose of hospital dentistry is to provide safe, efficient dental care when providing routine (non-emergency) dental services for Division clients who present special challenges that require the use of general anesthesia or IV conscious sedation services in an Ambulatory Surgical Center (ASC), inpatient or outpatient hospital setting. Refer to OAR 410-123-1060 for definitions.

(2) Division reimbursement for hospital dentistry is limited to covered services and may be prorated if non-covered dental services are performed during the same hospital visit:

(a) See OAR 410-123-1060 for a definition of Division hospital dentistry services;

(b) Refer to OAR 410-123-1220 and the "Covered and Non-Covered Dental Services" document.

(3) Hospital dentistry is intended for the following Division clients:

(a) Children, 18 or younger, who:

(A) Through age 3 have extensive dental needs;

(B) 4 years of age or older have unsuccessfully attempted treatment in the office setting with some type of sedation or nitrous oxide;

(C) Have acute situational anxiety, fearfulness, extreme uncooperative behavior, uncommunicative such as a client with developmental or mental disability, a client that is pre-verbal or extreme age where dental needs are deemed sufficiently important that dental care cannot be deferred;

(D) Need the use of general anesthesia or IV conscious sedation to protect the developing psyche;

(E) Have sustained extensive orofacial or dental trauma;

(F) Have physical, mental or medically compromising conditions; or

(G) Have a developmental disability or other severe cognitive impairment and one or more of the following characteristics that prevent routine dental care in an office setting:

(i) Acute situational anxiety and extreme uncooperative behavior;

(ii) A physically compromising condition;

(b) Adults, 19 or older, who:

(A) Have a developmental disability or other severe cognitive impairment, and one or more of the following characteristics that prevent routine dental care in an office setting:

(i) Acute situational anxiety and extreme uncooperative behavior;

(ii) A physically compromising condition;

(B) Have sustained extensive orofacial or dental trauma; or

(C) Are medically fragile, with complex medical needs, contractures or other significant medical conditions potentially making the dental office setting unsafe for the client.

(4) Hospital dentistry may not be used for:

(a) Client convenience. Refer to OAR 410-120-1200;

(b) A healthy, cooperative client with minimal dental needs; or

(c) Medical contraindication to general anesthesia or IV conscious sedation.

(5) The following information must be included in the client's dental record:

(a) IClient, parental or guardian written consent must be obtained prior to the use of general anesthesia or IV conscious sedation;

(b) Justification for the use of general anesthesia or IV conscious sedation. The decision to use general anesthesia or IV conscious sedation must take into consideration:

(A) Alternative behavior management modalities;

(B) Client's dental needs;

(C) Quality of dental care;

(D) Quantity of dental care;

(E) Client's emotional development;

(F) Client's physical considerations;

(c) If treatment in an office setting is not possible, documentation in the client's dental record must explain why, in the estimation of the dentist, the client will not be responsive to office treatment;

(d) The Division, CCO or PHP may require additional documentation when reviewing requests for prior authorization (PA) of hospital dentistry services. See OAR 410-123-1160 and section (6) of this rule for additional information;

(e) If the dentist did not proceed with a previous hospital dentistry plan approved by the Division for the same client, the Division shall also require clinical documentation explaining why the dentist did not complete the previous treatment plan.

(6) Hospital dentistry always requires PA for the medical services provided by the facility:

(a) If a client is enrolled in a CCO or PHP and receives dental services under a Dental Care Organization (DCO) or the CCO:

(A) The dentist shall:

(i) Contact the CCO or PHP for PA requirements and arrangements; and

(ii) Submit documentation to all enrolled plans, the CCO or PHP, and DCO if applicable;

(B) The CCO or PHP and DCO must review the documentation and discuss any concerns they have, contacting the dentist as needed. This allows for mutual plan involvement and monitoring;

(C) The total response time may not exceed 14 calendar days from the date of submission of all required documentation for routine dental care and should follow urgent and emergent dental care timelines;

(D) The CCO or PHP shall pay for all facility and anesthesia services. The DCO, or CCO if they have integrated dental services, shall pay for all dental professional services;

(b) If a client is enrolled in a Physician Care Organization (PCO) and a DCO:

(A) The PCO shall pay for all facility and anesthesia services provided in an outpatient hospital setting or an ASC. The Division shall pay for all facility and anesthesia services provided in an inpatient hospital setting. The DCO shall pay for all dental professional services;

(B) The dentist shall:

(i) Contact the PCO, if services are to be provided in an outpatient setting or an ASC, for PA requirements and arrangements; or

(ii) Contact the Division, if services are to be provided in an inpatient setting; and

(iii) Submit documentation to both the PCO or the Division, and the DCO;

(C) The PCO or the Division and the DCO should review the documentation and discuss any concerns they have, contacting the dentist as needed. This allows for mutual plan involvement and monitoring;

(D) The total response time should not exceed 14 calendar days from the date of submission of all required documentation for routine dental care and should follow urgent and emergent dental care timelines;

(b) If a client is fee-for-service (FFS) for medical services and enrolled in a DCO:

(A) The dentist shall fax documentation and a completed American Dental Association (ADA) form to the Division. Refer to the Dental Services Provider Guide;

(B) If the client is assigned to a Primary Care Manager (PCM) through FFS medical, the client must have a referral from the PCM prior to the Division approving any hospital service;

(C) The Division shall pay for facility and anesthesia services. The DCO shall pay for all dental professional services;

(D) The Division shall issue a decision on PA requests within 30 days of receipt of the request;

(c) If a client is enrolled in an CCO or PHP and is FFS dental:

(A) The dentist must contact the CCO or PHP to obtain the PA and arrange for the hospital dentistry;

(B) The dentist shall submit required documentation to the CCO or PHP;

(C) The CCO or PHP shall pay for all facility and anesthesia services. The Division shall pay for all dental professional services;

(d) If a client is FFS for both medical and dental:

(A) The dentist shall fax documentation and a completed ADA form to the Division. Refer to the Dental Services Provider Guide;

(B) The Division shall pay for all facility, anesthesia services and dental professional charges.

Stat. Auth.: ORS 413.042, 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 55-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 16-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 41-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 46-2011, f. 12-23-11, cert. ef. 1-1-12; DMAP 13-2013, f. 3-27-13, cert. ef. 4-1-13; DMAP 28-2013(Temp), f. 6-26-13, cert. ef. 7-1-13 thru 12-28-13

410-123-1600

Coordinated Care Organizations and Prepaid Health Plans

(1) The Division contracts with Coordinated Care Organizations (CCOs), Prepaid Health Plans (PHPs) and Primary Care Managers (PCM) to provide medical services for clients under the Division (Title XIX and Title XXI services):

(a) PHPs for dental services are called Dental Care Organizations (DCO). See OAR chapter 410, division 120 (General Rules) and division 141 (Oregon Health Plan Rules) for definitions and responsibilities;

(b) CCOs provide integrated and coordinated care services, including physical health, behavioral health, and by no later than July 1, 2014, dental health. See OAR chapter 410, division 120 (General Rules) and division 141 (Oregon Health Plan Rules) for definitions and responsibilities;

(c) See General Rules OAR 410-120-1210(4) — Medical Assistance Programs and Delivery Systems for a description of how clients receive services through CCOs, PHPs and PCMs.

(2) The Division prepays DCOs, and CCOs that have integrated dental services, to cover dental services, including the professional component of any services provided in an Ambulatory Surgical Center (ASC) or an outpatient or inpatient hospital setting for hospital dentistry. See OAR 410-123-1490 for more information about hospital dentistry.

(3) The Division may not pay for services covered by a CCO or PHP; reimbursement is a matter between the CCO/PHP and the provider.

(4) For clients enrolled in a DCO, or CCO responsible for dental services, the dental provider must coordinate all dental services with the client's DCO or CCO prior to providing services.

Stat. Auth.: ORS 413.042, 414.065 & 414.651

Stats. Implemented: ORS 414.651

Hist.: OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; DMAP 16-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 28-2013(Temp), f. 6-26-13, cert. ef. 7-1-13 thru 12-28-13

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Rule Caption: Clarify current practices in rule, provide rule language clarification for home health services.

Adm. Order No.: DMAP 29-2013

Filed with Sec. of State: 6-27-2013

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Rules Amended: 410-127-0020, 410-127-0040, 410-127-0060, 410-127-0080
Subject: These home health services are amended to clarify current practices in rule, provide rule language clarification and update definitions based on provider, stakeholder and the Oregon Association for Home Care participation and input in the Rule Advisory Committee meeting (RAC) held on March 27, 2013.
Rules Coordinator: Cheryl Peters—(503) 945-6527

410-127-0020
Definitions

(1) Acquisition Cost — The net invoice price of the item, supply, or equipment plus shipping and/or postage for the item.

(2) Assessment — Procedures by which a client's health strengths, weaknesses, problems, and needs are identified.

(3) Custodial Care — Provision of services and supplies that can safely be provided by non-medical or unlicensed personnel.

(4) Evaluation — A systematic objective assessment of the client for the purpose of forming a plan of treatment; and, a judgment of the effectiveness of care and measurement of treatment progress. The evaluation of direct care and effectiveness of care plans and interventions is an ongoing activity.

(5) Home — A place of temporary or permanent residence used as a person's home. This does not include a hospital, nursing facility, or intermediate care facility, but does include assisted living facilities, residential care facilities and adult foster care homes.

(6) Home Health Agency A public or private agency or organization which has been certified by Medicare as a Medicare home health agency and which is licensed by the Authority as a home health agency in Oregon, and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997. Home health agency does not include:

(a) Any visiting nurse service or home health service conducted by and for those who rely upon spiritual means through prayer alone for healing in accordance with tenets and practices of a recognized church or religious denomination;

(b) Health services offered by county health departments that are not formally designated and funded as home health agencies within the individual departments;

(c) Personal care services that do not pertain to the curative, rehabilitative or preventive aspect of nursing.

(7) Home Health Aide — A person who meets the criteria for Home Health Aide defined in the Medicare Conditions of Participation 42 CFR 484.36 and certified by the Board of Nursing.

(8) Home Health Aide Services — Services of a Home Health Aide must be provided under the direction and supervision of a registered nurse or licensed therapist. The focus of care shall be to provide personal care and/or other services under the plan of care which supports curative, rehabilitative or preventive aspects of nursing. These services are provided only in support of skilled nursing, physical therapy, occupational therapy, or speech therapy services. These services do not include custodial care.

(9) Home Health Services — Only the services described in the Division of Medical Assistance Programs (Division) Home Health Services provider guide.

(10) Medicaid Home Health Provider — A Home Health Agency licensed by Health Services, Health Care Licensure and Certification certified for Medicare and enrolled with the Division as a Medicaid provider.

(11) Medical Supplies — Supplies prescribed by a physician as a necessary part of the plan of care being provided by the Home Health Agency.

(12) OASIS (Outcome and Assessment Information Set) — a client specific comprehensive assessment that identifies the client's need for home care and that meets the client's medical, nursing, rehabilitative, social and discharge planning needs.

(13) Occupational Therapy Services — Services provided by a registered occupational therapist or certified occupational therapy assistant supervised by a registered occupational therapist, due to the complexity of the service and client's condition. The focus of these services shall be curative, rehabilitative or preventive and must be considered specific and effective treatments for a client's condition under accepted standards of medical practice. Teaching the client, family and/or caregiver task oriented therapeutic activities designed to restore function and/or independence in the activities of daily living is included in this skilled service. Occupational Therapy Licensing Board ORS 675.210-675.340 and the Uniform Terminology for Occupational Therapy established by the American Occupational Therapy Association, Inc. govern the practice of occupational therapy.

(14) Physical Therapy Services — Services provided by a licensed physical therapist or licensed physical therapy assistant under the supervision of a licensed physical therapist, due to the inherent complexity of the service and the client's condition. The focus of these services shall be curative, rehabilitative or preventive and must be considered specific and effective treatments for a patient's condition under accepted standards of medical practice. Teaching the client, family and/or caregiver the necessary techniques, exercises or precautions for treatment and/or prevention of illness or injury is included in this skilled service. Physical Therapy Licensing Board ORS 688.010 to 688.235 and Standards for Physical Therapy as well as the Standards of Ethical Conduct for the Physical Therapy Assistant established by the American Physical Therapy Association govern the practice of physical therapy. Physical Therapy shall not include radiology or electrosurgery.

(15) Plan of Care — Written instructions describing how care is to be provided. The plan is initiated by the admitting registered nurse, physical therapist, occupation therapist or speech therapist and certified by the prescribing physician. The plan of care must include the client's condition, rationale for the care plan, including justification for the skill level of care and the summary of care for additional certification periods. This includes, but is not limited to:

(a) All pertinent diagnoses;
(b) Mental status;
(c) Types of services;
(d) Specific therapy services;
(e) Frequency, and duration of service delivery;
(f) Supplies and equipment needed;
(g) Prognosis;
(h) Rehabilitation potential;
(i) Functional limitations;
(j) Activities permitted;
(k) Nutritional requirements;
(l) Medications and treatments;
(m) Safety measures;
(n) Discharge plans;
(o) Teaching requirements;
(p) Individualized, measurably objective short-term and /or long-term functional goals;
(q) Other items as indicated.

(16) Practitioner — A person licensed pursuant to Federal and State law to engage in the provision of health care services within the scope of the practitioner's license and certification.

(17) Responsible Unit — The agency responsible for approving or denying payment authorization.

(18) Skilled Nursing Services — The client care services pertaining to the curative, restorative or preventive aspects of nursing performed by a registered nurse or under the supervision of a registered nurse, pursuant to the plan of care established by the prescribing practitioner in consultation with the Home Health Agency staff. Skilled nursing emphasizes a high level of nursing direction, observation and skill. The focus of these services shall be the use of the nursing process to diagnose and treat human responses to actual or potential health care problems, health teaching, and health counseling. Skilled nursing services include the provision of direct client care and the teaching, delegation and supervision of others who provide tasks of nursing care to clients, as well as phlebotomy services. Such services will comply with the Nurse Practice Act and administrative rules of the Oregon State Board of Nursing and Health Division, division 27, Home Health Agencies, which rules are by this reference made a part hereof.

(19) Speech and Language Pathology Services — Services provided by a licensed speech-language pathologist due to the inherent complexity of the service and the patient's condition. The focus of these services shall be curative, rehabilitative or preventive and must be considered specific and effective treatment for a patient's condition under accepted standards of medical practice. Teaching the client, family and/or caregiver task oriented therapeutic activities designed to restore function, and/or compensatory techniques to improve the level of functional communication ability is included in this skilled service. Speech-Language Pathology and Audiologist Licensing Board ORS 681.205 to 681.991 and the Standards of Ethics established by the American Speech and Hearing Association, govern the practice of speech and language pathology.

(20) Title XVIII (Medicare) — Title XVIII of the Social Security Act.

(21) Title XIX (Medicaid) — Title XIX of the Social Security Act.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409.040 & 413.042
Stats. Implemented: ORS 414.065

Hist.: SSD 4-1983, f. 5-4-83, ef. 5-5-83; SSD 10-1990, f. 3-30-90, cert. ef. 4-1-90; HR 28-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 411-075-0001; HR 12-1991, f. & cert. ef. 3-1-91; HR 14-1992, f. & cert. ef. 6-1-92; HR 15-1995, f. & cert. ef. 8-1-95; OMAP 4-1998(Temp), f. & cert. ef. 2-5-98 thru 7-15-98; OMAP 24-1998, f. & cert. ef. 7-15-98; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 36-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 1-2003, f. 1-31-03, cert. f. 2-1-03; DMAP 33-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 29-2013, f. & cert. ef. 6-27-13

410-127-0040
Coverage

(1) Home health services are made available on a visiting basis to eligible clients in their homes as part of a written "plan of care."

(2) Home health services must be prescribed by a physician and the signed order must be on file at the home health agency. The prescription must include the ICD-9-CM or ICD-10-CM diagnosis code indicating the reason the home health services are requested. The orders on the plan of care must specify the type of services to be provided to the client, with respect to the professional who will provide them, the nature of the individual services, specific frequency and specific duration. The orders must clearly indicate how many times per day, each week and/or each month the services are to be provided. The plan of care must include the client's condition, the rationale for the care plan including justification for the required skill level of care, and the summary of care for additional certification periods.

(3) The plan of care must be reviewed and signed by the physician every two months to continue services.

(4) The following services or items are covered, if diagnoses are on the portion of the prioritized list above the line funded by the Legislature:

(a) Skilled nursing services;

(b) Skilled nursing evaluation (includes Outcome and Assessment Information Set (OASIS) assessment);

(c) Home Health aide services;

(d) Occupational therapy services;

(e) Occupational therapy evaluation (may include OASIS Assessment);

(f) Physical therapy services;

(g) Physical therapy evaluation (may include OASIS Assessment);

(h) Speech and language pathology services (may include OASIS Assessment;

(i) Speech and language pathology evaluation (may include OASIS assessment);

(j) Medical/surgical supplies.

Stat. Auth.: ORS 409.040 & 413.042
Stats. Implemented: ORS 414.065
Hist.: PWC 682, f. 7-19-74, ef. 8-11-74; PWC 798, f. & ef. 6-1-76; AFS 8-1979, f. 3-30-79, ef. 4-1-79; Renumbered from 461-019-0400 by Chapter 784, Oregon Laws 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 4-1983, f. 5-4-83, ef. 5-5-83; SSD 10-1990, f. 3-30-90, cert. ef. 4-1-90; HR 28-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 411-075-0000; HR 14-1992, f. & cert. ef. 6-1-92; HR 15-1995, f. & cert. ef. 8-1-95; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00; DMAP 29-2013, f. & cert. ef. 6-27-13

410-127-0060
Reimbursement and Limitations

(1) Reimbursement. The Division of Medical Assistance Programs (Division) reimburses home health services on a fee schedule by type of visit (see home health rates and copayment chart on the Oregon Health Authority (OHA) Web site at: http://www.dhs.state.or.us/policy/healthplan/guides/homehealth/main.html.

(2) The Division recalculates its home health services rates every other year. The Division will reimburse home health services at a level of 74% of Medicare costs reported on the audited, most recently accepted or submitted Medicare Cost Reports prior to the rebase date and pending approval from the Centers for Medicare and Medicaid Services (CMS), and if indicated, Legislative funding authority.

(3) The Division will request the Medicare Cost Reports from home health agencies with a due date, and will recalculate potential rates based on the Medicare Cost Reports received by the requested due date. It is the responsibility of the home health agency to submit requested cost reports by the date requested.

(4) The Division reimburses only for service which is medically appropriate.

(5) Limitations:

(a) Limits of covered services:

(A) Skilled nursing visits are limited to two visits per day with payment authorization;

(B) All therapy services are limited to one visit or evaluation per day for physical therapy, occupational therapy or speech and language pathology services. Therapy visits require payment authorization;

(C) The Division will authorize home health visits for clients with uterine monitoring only for medical problems, which could adversely affect the pregnancy and are not related to the uterine monitoring;

(D) Medical supplies must be billed at acquisition cost and the total of all medical supply revenue codes may not exceed $50 per day. Only supplies that are used during the visit or the specified additional supplies used for current client/caregiver teaching or training purposes as medically necessary are billable. Client visit notes must include documentation of supplies used during the visit or supplies provided according to the current plan of care;

(E) Durable medical equipment must be obtained by the client by prescription through a durable medical equipment provider.

(b) Not covered service:

(A) Service not medically appropriate;

(B) A service whose diagnosis does not appear on a line of the Prioritized List of Health Services which has been funded by the Oregon Legislature (OAR 410-141-0520);

(C) Medical Social Worker service;

(D) Registered dietician counseling or instruction;

(E) Drug and or biological;

(F) Fetal non-stress testing;

(G) Respiratory therapist service;

(H) Flu shot;

(I) Psychiatric nursing service.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: PWC 682, f. 7-19-74, ef. 8-11-74; PWC 798, f. & ef. 6-1-76; PWC 854(Temp), f. 9-30-77, ef. 10-1-77 thru 1-28-78; Renumbered from 461-019-0420 by Chapter 784, Oregon Laws 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 4-1983, f. 5-4-83, ef. 5-5-83; SSD 10-1990, f. 3-30-90, cert. ef. 4-1-90; HR 28-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 411-075-0010; HR 14-1992, f. & cert. ef. 6-1-92; HR 15-1995, f. & cert. ef. 8-1-95; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 77-2003, f. & cert. ef. 10.1.03; DMAP 16-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 33-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 22-2011(Temp), f. 7-29-11, cert. ef. 8-1-11 thru 1-25-12; DMAP 39-2011, f. 12-15-11, cert. ef. 1-1-12; DMAP 29-2013, f. & cert. ef. 6-27-13

410-127-0080
Prior Authorization

(1) Home health providers must obtain prior authorization (PA) for services as specified in rule.

(2) Providers must request PA as follows (see the Home Health Supplemental Information booklet for contact information) and include the documentation requirements from the Supplemental (e.g. plan of care, primary diagnosis, initial assessment, evaluation, etc.):

(a) For clients enrolled in a Coordinated Care Organization (CCO) or a Prepaid Health Plan (PHP), from the CCO or the PHP;

(b) For all other clients, from the Division of Medical Assistance Programs (Division).

(3) For services requiring authorization, providers must contact the responsible unit for authorization within five working days following initiation or continuation of services. The FAX or postmark date on the request will be honored as the request date. It is the provider's responsibility to obtain payment authorization. Authorization will be given based on medical appropriateness and appropriate level of care, cost and/or effectiveness as supported by submitted documentation. The plan of care submitted must include the client's condition, the rationale for the care plan, including justification for the required skill level of care and the summary of care for additional certification periods.

(4) Payment authorization does not guarantee reimbursement (e.g. eligibility changes, incorrect identification number, provider contract ends).

(5) For rules related to authorization of payment, including retroactive eligibility, see General Rules, 410-120-1320.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist.: PWC 682, f. 7-19-74, ef. 8-11-74; PWC 798, f. & ef. 6-1-76; AFS 8-1979, f. 3-30-79, ef. 4-1-79; Renumbered from 461-019-0410 by Chapter 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 4-1983, f. 5-4-83, ef. 5-5-83; SSD 6-1986, f. & ef. 4-24-86; SSD 10-1990, f. 3-30-90, cert. ef. 4-1-90; HR 28-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 411-075-0005; HR 12-1991, f. & cert. ef. 3-1-91; HR 30-1992(Temp), f. & cert. ef. 9-25-92; HR 2-1993, f. 2-19-93, cert. ef. 2-20-93; HR 15-1995, f. & cert. ef. 8-1-95; OMAP 15-1999, f. & cert. ef. 4-1-99; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 1-2003, f. 1-31-03, cert. f. 2-1-03; OMAP 91-2003, f. 12-30-03 cert. ef. 1-1-04; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 33-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 29-2013, f. & cert. ef. 6-27-13

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Rule Caption: Implement Federal and state requirements in nursing facility with payment rate changes rule language clarification
Adm. Order No.: DMAP 30-2013
Filed with Sec. of State: 6-27-2013
Certified to be Effective: 6-27-13

Notice Publication Date: 6-1-2013
Rules Amended: 410-142-0020, 410-142-0290
Subject: This program will be implemented May 1, 2013. The Division needs to amend the rules listed to incorporated federal compliance requirements for payment when a client resides in a nursing facility (NF) and elects hospice care; make rate changes, clarify language, and update definitions based on provider, stakeholder, and Oregon Hospice Association participation and input in the Rules Advisory Committee (RAC) held on March 28, 2013.
Rules Coordinator: Cheryl Peters—(503) 945-6527

410-142-0020
Definitions

(1) Accredited/Accreditation: A designation by an accrediting organization that a hospice program has met standards that have been developed to indicate a quality program.

(2) Ancillary staff: Staff that provides additional services to support or supplement hospice care.

(3) Assessment: Procedures by which strengths, weaknesses, problems, and needs are identified and addressed.

(4) Attending physician: A physician who is a doctor of medicine or osteopathy and is identified by the client, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the client's medical care.

(5) Bereavement counseling: Counseling services provided to the client's family before and after the client's death. Bereavement counseling is required to be offered per the Conditions of Participation and is a non-reimbursable hospice service.

(6) Bundled Rate: the Nursing Facility (NF) rate as defined in 411-070-0085.

(7) Client-family unit includes a client who has a life threatening disease with a limited prognosis and all others sharing housing, common ancestry or a common personal commitment with the client.

(8) Conditions of Participation (CoPs): The applicable federal regulations that hospice programs are required to comply with in order to participate in the federal Medicare and Medicaid programs.

(9) Coordinated: When used in conjunction with the phrase "hospice program," means the integration of the interdisciplinary services provided by client-family care staff, other providers and volunteers directed toward meeting the hospice needs of the client.

(10) Coordination of Care (COC): The federal regulations for coordination of client care between the hospice and the nursing facility that hospice programs are required to comply with in order to serve hospice clients in a nursing facility and participate in the federal Medicare and Medicaid programs.

(11) Coordinator: A registered nurse designated to coordinate and implement the care plan for each hospice client.

(12) Counseling: A relationship in which a person endeavors to help another understand and cope with problems as a part of the hospice plan of care.

(13) Curative: Medical intervention used to ameliorate the disease.

(14) Dying: The progressive failure of the body systems to retain normal functioning, thereby limiting the remaining life span.

(15) Family: The relatives and/or other significantly important persons who provide psychological, emotional, and spiritual support of the client. The "family" need not be blood relatives to be an integral part of the hospice care plan.

(16) Hospice: A public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill clients, and is certified by the federal Centers for Medicare and Medicaid Services as a program of hospice services meeting current standards for Medicare and Medicaid reimbursement and Medicare Conditions of Participation; and currently licensed by the Oregon Health Authority (Authority), Public Health Division.

(17) Hospice continuity of care: Services that are organized, coordinated and provided in a way that is responsive at all times to client/family needs, and which are structured to assure that the hospice is accountable for its care and services in all settings according to the hospice plan of care.

(18) Hospice routine home care: Formally organized services designed to provide and coordinate hospice interdisciplinary team services to client/family in the place of residence. The hospice will deliver at least 80 percent of the care in the place of residence.

(19) Hospice philosophy: Hospice recognizes dying as part of the normal process of living and focuses on maintaining the quality of life. Hospice exists in the hope and belief that through appropriate care and the promotion of a caring community sensitive to their needs, clients and their families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them.

(20) Hospice Program: A coordinated program of home and inpatient care, available 24 hours a day, that uses an interdisciplinary team of personnel trained to provide palliative and supportive services to a client-family unit experiencing a life threatening disease with a limited prognosis. A hospice program is an institution for purposes of ORS

(21) Hospice Program registry: A registry of all licensed hospice programs maintained by the Authority, Public Health Division.

(22) Hospice services: Items and services provided to a client/family unit by a hospice program or by other clients or community agencies under a consulting or contractual arrangement with a hospice program. Hospice services include home care, inpatient care for acute pain and symptom management or respite, and bereavement services provided to meet the physical, psychosocial, emotional, spiritual and other special needs of the client/family unit during the final stages of illness, dying and the bereavement period.

(23) Illness: The condition of being sick, diseased or with injury.

(24) Interdisciplinary team: A group of individuals working together in a coordinated manner to provide hospice care. An interdisciplinary team includes, but is not limited to, the client-family unit, the client's attending physician or clinician and one or more of the following hospice program personnel: Physician, nurse practitioner, nurse, hospice aide (nurse's aide), occupational therapist, physical therapist, trained lay volunteer, clergy or spiritual counselor, and credentialed mental health professional such as psychiatrist, psychologist, psychiatric nurse or social worker.

(25) Medical director: The medical director must be a hospice employee who is a doctor of medicine or osteopathy who assumes overall responsibility for the medical component of the hospice's client care program.

(26) Medicare certification: Licensed and certified by the Authority, Public Health Division as a program of services eligible for reimbursement.

(27) Nursing facility: A facility licensed and certified by the Department of Human Services (Department) as a nursing facility and defined in OAR 411-070.

(28) Nursing facility services: The bundled rate of services which incorporates all services, including room and board, for which the nursing facility is paid per OAR 411-070.

(29) Pain and Symptom Management: For the hospice program, the focus of intervention is to maximize the quality of the remaining life through the provision of palliative services that control pain and symptoms. Hospice programs recognize that when a client/family is faced with terminal illness, stress and concerns may arise in many aspects of their lives. Symptom management includes assessing and responding to the physical, emotional, social and spiritual needs of the client/family.

(30) Palliative services: Comfort services of intervention that focus primarily on reduction or abatement of the physical, psychosocial and spiritual symptoms of terminal illness. Palliative therapy:

(a) Active: Is treatment to prolong survival, arrest the growth or progression of disease. The person is willing to accept moderate side-effects and psychologically is fighting the disease. This person is not likely to be a client for hospice;

(b) Symptomatic: Is treatment for comfort, symptom control of the disease and improves the quality of life. The person is willing to accept minor side-effects and psychologically wants to live with the disease in comfort. This person would have requested and been admitted to a hospice.

(31) Period of crisis: A period in which the client requires continuous care to achieve palliation or management of acute medical symptoms.

(32) Physician designee: Means a doctor of medicine or osteopathy designated by the hospice who assumes the same responsibilities and obligations as the medical director when the medical director is not available.

(33) Primary caregiver: The person designated by the client or representative. This person may be family, a client who has personal significance to the client but no blood or legal relationship (e.g., significant other), such as a neighbor, friend or other person. The primary caregiver assumes responsibility for care of the client as needed. If the client has no designated primary caregiver the hospice may, according to client program policy, make an effort to designate a primary caregiver.

(34) Prognosis: The amount of time set for the prediction of a probable outcome of a disease.

(35) Representative: An individual who has been authorized under state law to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill client who is mentally or physically incapacitated.

(36) Terminal illness: An illness or injury which is forecast to result in the death of the client, for which treatment directed toward cure is no longer believed appropriate or effective.

(37) Terminally Ill means that the client has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

(38) Volunteer: An individual who agrees to provide services to a hospice program without monetary compensation.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 16-1995, f. & cert. ef. 8-1-95; OMAP 34-2000, f. 9-29-00, cert. ef. 10-1-00; DMAP 18-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 36-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 40-2011, f. 12-15-11, cert. ef. 1-1-12; DMAP 18-2013(Temp), f. 4-11-13, cert. ef. 5-1-13 thru 10-28-13; DMAP 30-2013, f. & cert. ef. 6-27-13

410-142-0290

Hospice Services in a Nursing Facility

(1) Pursuant to Title XIX, Section 1902 and 1905, federal statute prohibits the state from paying nursing facility (NF) providers directly for NF services when their Medicaid residents elect hospice care. In these instances, the Centers for Medicare and Medicaid Services (CMS) require the state to pay the hospice provider the additional amount equal to at least 95% of the per diem rate the state would have paid to the NF for NF services for that client in that facility.

(2) When a client resides in a NF and elects hospice care, the hospice provider and the NF must have a written contract which addresses the provision of hospice care and the method upon which the hospice will pay the NF. The hospice and the NF must maintain a copy of the completed and signed contract on file and it must be available upon request.

(3) Reimbursement when a client resides in a NF and elects hospice care:

(a) In accordance with CMS 4308.2, "when hospice care is furnished to an individual residing in a NF, the state will pay hospice an additional amount on routine home care or continuous home care days to take into account the room and board furnished by the NF. In this context, the term 'room and board' includes performance of personal care services, including assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a residents' room, and supervision and assisting in the use of durable medical equipment and prescribed therapies," as well as any other services considered under the bundled rate for which the NF is paid pursuant to OAR 411-070.

(b) The hospice shall bill the Division of Medical Assistance Programs (Division) directly for the hospice care provided (under routine home care, Revenue code 651, or continuous home care, Revenue code 652) and for the cost of NF services at their usual and customary rate for NF services delivered in that NF for that client;

(c) The Division shall pay the hospice provider for the hospice care provided and not to exceed 100% of the current NF basic, complex medical, pediatric, or special contract rate according to the rate schedule for NF services delivered in that NF for that client;

(d) The hospice provider must reimburse the nursing facility according to their contract and after the hospice receives payment from the Division for that NF for that client; and

(e) Reimbursement for services provided under this rule is available only if the recipient of the services is Medicaid-eligible, hospice-eligible, and been found to need NF care through the Pre-Admission Screening process under OAR 411-070-0040.

(4) NF Services Overpayment: Any payment received from the Division by a NF for services delivered after a client has elected hospice care shall adjust their claims from the day the client first elected hospice care. Failure to submit an adjustment subjects the NF to potential sanctions and all means of overpayment recovery authorized under OAR chapter 410, division 120.

(5) Coordination of Care (COC) must be provided according to CMS Conditions of Participation (CoPs), 42CFR418.112 for hospice and nursing facilities.

(6) Coordinated Care Organization (CCO) and Prepaid Health Plan (PHP) clients who reside in a NF and elect hospice care shall remain in the CCO and PHP for all care other than hospice services in the NF. Hospice services for a resident in a NF shall be excluded from CCO and PHP capitation and the hospice must bill the Division directly for payment of hospice and NF services.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist.: DMAP 34-2012, f. & cert. ef. 7-20-12; DMAP 18-2013(Temp), f. 4-11-13, cert. ef. 5-1-13 thru 10-28-13; DMAP 30-2013, f. & cert. ef. 6-27-13

Rule Caption: Add definitions, Change in coverage to Part D Medicare for certain drugs.
Adm. Order No.: DMAP 31-2013
Filed with Sec. of State: 6-27-2013
Certified to be Effective: 6-27-13
Notice Publication Date: 6-1-2013
Rules Amended: 410-120-1210
Subject: The General Rules program administrative rules govern Division payments for services to clients. Having temporarily amended 410-120-1210 effective January 1, 2013, DMAP will permanently amend this rule to implement changes used by the Centers for Medicare and Medicaid Services (CMS). January 1, 2013 Medicare Part D started covering barbiturates "used in the treatment of epilepsy, cancer, or a chronic mental health disorder" and benzodiazepines. Barbiturates and benzodiazepines were among the excluded drugs that the Division covered for its Medicaid beneficiaries. Since the coverage of barbiturates under Part D is limited to the treatment of epilepsy, cancer or a chronic mental health disorders, Division will continue to cover barbiturates to the extent it covers that drug for a condition other than the three covered by Part D.
Rules Coordinator: Cheryl Peters—(503) 945-6527

410-120-1210

Medical Assistance Benefit Packages and Delivery System

(1) The services clients are eligible to receive are based upon the benefit package for which they are eligible.. Not all packages receive the same benefits.

(2) The Division of Medical Assistance Programs (Division) benefit package description, codes, eligibility criteria, coverage, limitations and exclusions are identified in these rules.

(3) The limitations and exclusions listed here are in addition to those described in OAR 410-120-1200 and in each of the Division chapter 410 OARs.

(4) Benefit package descriptions:

(a) Oregon Health Plan (OHP) Plus:

(A) Benefit package identifier: BMH

(B) Eligibility criteria:As defined in federal regulations and in the 1115 OHP waiver demonstration, a client is categorically eligible for medical assistance if he or she is eligible under a federally defined mandatory, selected, optional Medicaid program or the Children's Health Insurance Program (CHIP) and also meets Oregon Health Authority (Authority) adopted income and other eligibility criteria.

(C) Coverage includes:

(i) Services above the funding line on the Health Services Commission's (HSC) Prioritized List of Health Services, (OAR 410-141-0480 through 410-141-0520);

(ii) Ancillary services, (OAR 410-141-0480);

(iii) Substance use disorder treatment and recovery services provided through local Substance use disorder treatment and recovery providers;

(iv) Mental health services based on the HSC Prioritized List of Health Services, to be provided through Community Mental Health Programs or their subcontractors;

(v) Hospice;

(vi) Post-hospital extended care benefit, up to a 20-day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043), or by the Fully Capitated Health Plan (FCHP) for clients enrolled in an FCHP;

(vii) Cost sharing (e.g., copayments) may apply to some covered services;

(B) Limitations: The following services have limited coverage for non pregnant adults age 21 and older. (Refer to the cited OAR chapters and divisions for details):

(i) Selected dental (OAR chapter 410, division 123);

(ii) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140);

(b) OHP Standard:

(A) Benefit Package identifier code: KIT;

(B) Eligiblity criteria: Adults and childless couples who are eligible through the 1115 Medicaid expansion waiver and meet Authority-adopted income and other eligibility criteria; the Department identifies these clients through the program acronym, OHP-OPU;

(C) Coverage includes:

(i) Services above the funding line on the HSC Prioritized List, (OAR 410-141-0480 through 410-141-0520);

(ii) Ancillary services, (OAR 410-141-0480);

(iii) Outpatient substance use disorder treatment and recovery services provided through local substance use disorder treatment and recovery providers;

(iv) Outpatient mental health services based on the HSC Prioritized List of Health Services, to be provided through Community Mental Health Programs or their subcontractors;

(v) Hospice;

(vi) Post-hospital extended care benefit, up to a 20-day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043) or by the Fully Capitated Health Plan (FCHP) for clients enrolled in an FCHP.

(B) Limitations: The following services have limited coverage (Refer to the cited OAR chapters and divisions for details):

(i) Selected dental (OAR chapter 410, division 123);

(ii) Selected durable medical equipment and medical supplies (OAR chapter 410, division 122 and 130);

(iii) Selected home enteral/parenteral services (OAR chapter 410, division 148);

(iv) Other limitations as identified in individual Division program administrative rules.

(C) Exclusions: The following services are not covered. Refer to the cited OAR chapters and divisions for details:

(i) Acupuncture services, except when provided for substance use disorder treatment and recovery services(OAR chapter 410, division 130);

(ii) Chiropractic and osteopathic manipulation services (OAR chapter 410, division 130);

(iii) Hearing aids and related services (i.e., exams for the sole purpose of determining the need for or the type of hearing aid), (OAR chapter 410, division 129);

(iv) Home health services (OAR chapter 410, division 127), except when related to limited EPIV services (OAR chapter 410, division 148);

(v) Non-emergency medical transportation (OAR chapter 410, division 136);

(vi) Occupational therapy services (OAR chapter 410, division 131);

(vii) Physical therapy services (OAR chapter 410, division 131);

(viii) Private duty nursing services (OAR chapter 410, division 132), except when related to limited EPIV services;

(ix) Speech and language therapy services (OAR chapter 410, division 129);

(x) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140);

(xi) Other limitations as identified in individual Division program administrative rules, chapter 410.

(c) OHP with Limited Drug:

(A) Benefit Package identifier: BMM, BMD;

(B) Eligibility criteria: Eligible clients are eligible for Medicare and Medicaid benefits;

(C) Coverage includes:

(i) Services covered by Medicare and OHP Plus as described in section (4) of these rules;

(D) Limitations:

(i) The same as OHP Plus, as described in section (4) of these rules;

(ii) Drugs excluded from Medicare Part D coverage that are also covered under the medical assistance programs, subject to applicable limitations for covered prescription drugs (Refer to OAR chapter 410, division 121 for specific limitations). These drugs include but are not limited to:

(I) Over-the-counter (OTC) drugs;

(II) Barbiturates(except for dual eligible individuals when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D will cover those indications).

(E) Exclusions: Drugs or classes of drugs covered by Medicare Part D Prescription Drug.

(F) Payment for services is limited to the Medicaid allowed payment less the Medicare payment up to the amount of co-insurance and deductible;

(G) Cost sharing may apply to some covered services, however, cost sharing related to Medicare Part D is not covered since drugs covered by Part D are excluded from the benefit package;

(d) Qualified Medicare Beneficiary (QMB)-Only:

(A) Benefit Package identifier code MED:

(B) Eligibility criteria: Eligibleclients are Medicare Part A and B beneficiaries who have limited income but do not meet the income standard for full medical assistance coverage.

(C) Coverage: Is limited to the co-insurance or deductible for the Medicare service. Payment is based on the Medicaid allowed payment less the Medicare payment up to the amount of co-insurance and deductible, but no more than the Medicare allowable;

(D) Providers may not bill QMB-only clients for the deductible and coinsurance amounts due for services that are covered by Medicare.

(e) Citizen/Alien-Waived Emergency Medical (CAWEM):

(A) Benefit Package identifier CWM:

(B) Eligibility criteria: Eligible clientsare non-qualified aliens that are not eligible for other Medicaid programs pursuant to Oregon Administrative Rules (OAR) 461-135-1070;

(C) Coverage is limited to:

(i) Emergency medical services as defined by 42 CFR 440.255. Sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part (the "prudent layperson standard" does not apply to the CAWEM emergency definition);

(ii) Labor and Delivery.

(D) Exclusions: The following services are not covered, even if they are sought as emergency services:

(i) Prenatal or postpartum care;

(ii) Sterilization;

(iii) Family Planning;

(iv) Preventive care;

(v) Organ transplants and transplant-related services;

(vi) Chemotherapy;

(vii) Hospice;

(viii) Home health;

(ix) Private duty nursing;

(x) Dialysis;

(xi) Dental services provided outside of an emergency department hospital setting;

(xii) Outpatient drugs or over-the-counter products;

(xiii) Non-emergency medical transportation;

(xiv) Therapy services;

(xv) Durable medical equipment and medical supplies;

(xvi) Rehabilitation services.

(f) CAWEM Plus-CHIP Prenatal coverage for CAWEM (benefit code CWX) — refer to OAR 410-120-0030 for coverage.

(5) Division clients are enrolled for covered health services to be delivered through one of the following means:

(a) Coordinated Care Organization (CCO):

(A) These clients are enrolled in a CCO that provides integrated and coordinated health care;

(B) CCO services are obtained from the CCO or by referral from the CCO that is responsible for the provision and reimbursement for physical health, substance use disorder treatment and recovery, mental health services or dental care.

(b) Prepaid Health Plan (PHP):

(A) These clients are enrolled in a PHP for their medical, dental or mental health care;

(B) Most non-emergency services are obtained from the PHP or require a referral from the PHP that is responsible for the provision and reimbursement for the medical, dental or mental health service;

(c) Physician Care Organization (PCO):

(A) These clients are enrolled in a PCO for their medical care;

(B) Inpatient hospital services are not the responsibility of the PCO and are governed by the Fee-for-Service Hospital Services Program rule (OAR 410 Division 125).

(d) Primary Care Managers (PCM):

(A) These clients are enrolled with a PCM for their medical care;

(B) Most non-emergency services provided to clients enrolled with a PCM require referral from the PCM.

(c) Fee-for-service (FFS):

(A) These clients are not enrolled in a CCO, PHP, PCO or assigned to a PCM;

(B) Subject to limitations and restrictions in individual program rules, the client can receive health care from any Division-enrolled provider that

accepts FFS clients. The provider will bill the Division directly for any covered service and will receive a fee for the service provided.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025, 414.065, 414.329, 414.705, 414.706, 414.707, 414.708, 414.710
Hist.: OMAP 46-2003(Temp), f. & cert. ef. 7-1-03 thru 12-15-03; OMAP 56-2003, f. 8-28-03, cert. ef. 9-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 38-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 36-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12; DMAP 63-2012(Temp), f. 12-27-12, cert. ef. 1-1-13 thru 6-29-13; DMAP 31-2013, f. & cert. ef. 6-27-13

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Rule Caption: Align with Department of Human Services OAR chapter 461, medical eligibility rules
Adm. Order No.: DMAP 32-2013
Filed with Sec. of State: 6-27-2013
Certified to be Effective: 6-27-13
Notice Publication Date: 2-1-2013
Rules Amended: 410-120-0006
Subject: The General Rules Program administrative rules govern the Division's payment for services provided to clients and medical assistance eligibility determinations made by the Oregon Health Authority. In coordination with the Department of Human Services' (Department) revision of medical eligibility rules in chapter 461, the Division is amending OAR 410-120-0006 to assure that the Division's medical eligibility rule aligns with and reflects information found in the Department's medical eligibility rules. In OAR 410-120-0006, the Division adopts in rule by reference Department eligibility rules and must update OAR 410-120-0006 in conjunction.
Rules Coordinator: Cheryl Peters—(503) 945-6527

410-120-0006
Medical Eligibility Standards

As the state Medicaid and CHIP agency, the Oregon Health Authority (Authority) is responsible for establishing and implementing eligibility policies and procedure consistent with applicable law. As outlined in 943-001-0020; the Authority, and the Department of Human Services (Department) work together to adopt rules to assure that medical assistance eligibility procedures and determinations are consistent across both agencies.

(1) The Authority adopts and incorporates by reference the rules established in OAR chapter 461 and in effect June 29,2013 for all medical eligibility requirements for medical assistance when the Authority conducts eligibility determinations.

(2) Any reference to OAR chapter 461 in Oregon Administrative Rules or contracts of the Authority are deemed to be references to the requirements of this rule and shall be construed to apply to all eligibility policies, procedures and determinations by or through the Authority.

(3) For purposes of this rule, references in OAR chapter 461 to the Department or to the Authority shall be construed to be references to both agencies.

(4) Effective on or after July 1, 2011 the Authority shall conduct medical eligibility determinations using the OAR chapter 461 rules which are in effect on the date the Authority makes the medical eligibility determination.

(5) A request for a hearing resulting from a determination under this rule, made by the Authority shall be handled pursuant to the hearing procedures set out in division 25 of OAR chapter 461. References to "the Administrator" in division 25 of chapter 461 or "the Department" are hereby incorporated as references to the "Authority."

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042 & 414.065
Hist.: DMAP 10-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 18-2011(Temp), f. & cert. ef. 7-15-11 thru 1-11-12; DMAP 21-2011(Temp), f. 7-29-11, cert. ef. 8-1-11 thru 1-11-12; DMAP 25-2011(Temp), f. 9-28-11, cert. ef. 10-1-11 thru 1-11-12; DMAP 36-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 1-2012(Temp), f. & cert. e.f 1-13-12 thru 7-10-12; DMAP 2-2012(Temp), f. & cert. ef. 1-26-12 thru 7-10-12; DMAP 3-2012(Temp), f. & cert. ef. 1-31-12 thru 2-1-12; DMAP 4-2012(Temp), f. 1-31-12, cert. ef. 2-1-12 thru 7-10-12; DMAP 9-2012(Temp), f. & cert. ef. 3-1-12 thru 7-10-12; DMAP 21-2012(Temp), f. 3-30-12, cert. ef. 4-1-12 thru 7-10-12; DMAP 25-2012(Temp), f. & cert. ef. 5-1-12 thru 7-10-12; Administrative correction 8-1-12; DMAP 35-2012(Temp), f. & cert. ef. 7-20-12 thru 1-15-13; DMAP 45-2012(Temp), f. & cert. ef. 10-5-12 thru 1-19-13; DMAP 50-2012, f. 10-31-12, cert. ef. 11-1-12; DMAP 53-2012(Temp), f. & cert. ef. 11-1-12 thru 4-29-13; DMAP 56-2012(Temp), f. 11-30-12, cert. ef. 12-1-12 thru 4-1-13; DMAP 60-2012, f. 12-27-12, cert. ef. 1-1-13; DMAP 65-2012(Temp), f. 12-28-12, cert. ef. 1-1-13 thru 6-29-13; DMAP 2-2013(Temp), f. & cert. e.f 1-8-13 thru 6-29-13; DMAP 3-2013(Temp), f. & cert. ef. 1-30-13 thru 6-29-13; DMAP 5-2013(Temp), f. & cert. ef. 2-20-13 thru 6-29-13; DMAP 7-2013(Temp), f. & cert. ef. 3-1-13 thru 6-29-13; DMAP 12-2013, f. 3-27-13, cert. ef. 4-1-13; DMAP 17-2013, f. & cert. ef. 4-10-13; DMAP 24-2013, f. & cert. ef. 5-29-13; DMAP 32-2013, f. & cert. ef. 6-27-13

Rule Caption: Correct the Authority's intent to exempt newly eligible third trimester women from mandatory enrollment
Adm. Order No.: DMAP 33-2013
Filed with Sec. of State: 6-27-2013
Certified to be Effective: 6-27-13
Notice Publication Date: 6-1-2013
Rules Amended: 410-141-3060
Subject: This rule establishes a process for the Authority to allow exemptions to enrollment for newly eligible women in their third trimester of pregnancy. CCOs will improve health, increase the quality, reliability, availability and continuity of care, as well as to reduce costs. CCOs will provide medical assistance recipients with health care services that are supported by alternative payment methodologies that focus on prevention and that use patient-centered primary care homes, evidence-based practices and health information technology to improve health and reduce health disparities. The Authority needs to amend these rules to ensure the Authority's intent for member choice when reaching the third trimester of pregnancy. This rule change needs to be in effect January 1, 2013, the start date of the current requirement for mandatory enrollment post 60 days from birth.
Rules Coordinator: Cheryl Peters—(503) 945-6527

410-141-3060
Enrollment Requirements in a CCO

(1) A client who is eligible for or receiving health services must enroll in a CCO as required by ORS 414.631, except as provided in ORS 414.631(2), (3), (4), and (5) and 414.632(2) or exempted by this rule.

(2) If, upon application or redetermination, a client does not select a CCO, the Authority shall enroll the client and the client's household in a CCO that has adequate health care access and capacity.

(3) For existing members of a PHP that has transitioned to a CCO, the Authority shall enroll those members in the CCO when the Authority certifies and contracts with the CCO. The Authority shall provide notice to the enrollees 30 days before the effective date.

(4) Existing members of a PHP that is on the path to becoming a CCO shall retain those members. The Authority shall enroll those members in the CCO when certification and contracting are complete. The Authority shall provide notice to the clients 30 days before the effective date.

(5) Unless otherwise exempted by sections (17) and (18) of this rule, existing clients receiving their physical health care services on a fee-for-service basis shall enroll in a CCO serving their area that has adequate health care access and capacity. They must enroll by November 1, 2012. The Authority shall send a notice to the clients 30 days before the effective date.

(6) The following apply to clients receiving health care services on a fee-for-service basis but behavioral health services in a MHO:

(a) The Authority shall enroll the client in a CCO that is serving the client's area before November 1, 2012;

(b) The client shall receive their behavioral health care services from that CCO;

(c) The client shall continue to receive their physical health care services on a fee-for-service basis; and

(d) On or after November 1, 2012, the Authority shall enroll the client in a CCO for both physical health and behavioral health care services, unless otherwise exempted by sections (17) and (18) of this rule.

(7) The following apply to clients enrolled in Medicare:

(a) A client may enroll in a CCO regardless of whether they are enrolled in Medicare Advantage;

(b) A client enrolled in Medicare Advantage, whether or not they pay their own premium, may enroll in a CCO, even if the CCO does not have a corresponding Medicare Advantage plan.

(c) A client may enroll with a CCO, even if the client withdrew from that CCO's Medicare Advantage plan. The CCO shall accept the client's enrollment if the CCO has adequate health access and capacity;

(d) A client may enroll with a CCO, even if the client is enrolled in Medicare Advantage with another entity.

(8) From August 1, 2012, until November 1, 2012, enrollment is required in service areas with adequate health care access and capacity to provide health care services through a CCO or PHP. The following outlines the priority of enrollment during this period in service areas where enrollment is required:

(a) Priority 1: The client must enroll in a CCO that serves that area and has adequate health care access and capacity;

(b) Priority 2: The client must enroll in a PHP if:

(A) A PHP serves an area that a CCO does not serve; or

(B) A PHP serves an area that a CCO serves, but the CCO has inadequate health care access and capacity to accept new members;

(c) Priority 3: The client shall receive services on a fee-for-service basis.

(9) From August 1, 2012, until November 1, 2012, enrollment is voluntary in service areas without adequate access and capacity to provide health care services through a CCO or PHP. If a client decides to enroll in a CCO or PHP, the priority of enrollment in section (8) applies.

(10) On or after November 1, 2012, CCO enrollment is required in all areas. The following outlines the priority of options to enroll in all service areas:

(a) Priority 1: The client must enroll in a CCO that serves that area and has adequate health care access and capacity;

(b) Priority 2: The client must enroll in a PHP on the path to becoming a CCO if:

(A) The PHP serves an area that a CCO does not serve; or

(B) The PHP serves an area that a CCO serves, but the CCO has inadequate health care services capacity to accept new members;

(c) Priority 3: The client must enroll in a PHP that is not on the path to becoming a CCO if:

(A) The PHP serves an area that a CCO does not serve; or

(B) The PHP serves an area that a CCO serves, but the CCO has inadequate health care access or capacity to accept new members;

(d) Priority 4: The client shall receive services on a fee-for-service basis.

(11) A client must enroll in a dental care organization (DCO) in a service area where a DCO has adequate dental care access and capacity, and a DCO is open to enrollment.

(12) A client may enroll in a DCO in a service area where a DCO has inadequate dental care access and capacity. In these service areas, a client may:

(a) Select any DCO open for enrollment; or

(b) Obtain dental services on a FFS basis.

(13) If a client receives physical health care through a PHP, PCM or on a fee-for-service basis, under circumstances allowed by this rule, the client must enroll in a mental (behavioral) health organization (MHO) in a service area where MHO enrollment is required. The following determines if a service area requires MHO enrollment:

(a) The service area has adequate behavioral health care access and capacity;

(b) A CCO does not serve in the area; or

(c) A CCO serves the area, but the CCO has inadequate health care access and capacity to accept new members:

(14) From August 1, 2012, until November 1, 2012, if a service area changes from required enrollment to voluntary enrollment, the member shall remain with the PHP for the remainder of their eligibility period or until the Authority or Department redetermines eligibility, whichever comes sooner, unless otherwise eligible to disenroll pursuant to OAR 410-41-3080.

(15) At the time of application or recertification, the primary person in the household shall select the CCO on behalf of all household members on the same household case. If the client is not able to choose a CCO, the client's representative shall make the selection.

(16) The Department or OYA shall select the CCO for a child in the legal custody of the Department or OYA, except for children in subsidized adoptions.

(17) The following populations are exempt from CCO enrollment:

(a) Populations expressly exempted by ORS 414.631(2) (a), (b) and (c), which includes:

(A) Persons who are non-citizens who are eligible for labor and delivery services and emergency treatment services;

(B) Persons who are American Indian and Alaskan Native beneficiaries; and

(C) Persons who are dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly.

(b) Newly eligible clients are exempt from enrollment with a CCO if the client became eligible when admitted as an inpatient in a hospital. The client shall receive health care services on a fee-for-service basis only until the hospital discharges the client. The client is not exempt from enrollment in a DCO.

(c) Children in the legal custody of the Department or OYA where the child is expected to be in a substitute care placement for less than 30 calendar days, unless:

(A) Access to health care on a fee-for-service basis is not available; or

(B) Enrollment would preserve continuity of care.

(d) Clients with major medical health insurance coverage, also known as third party liability, except as provided in OAR 410-141-3050;

(e) Clients receiving prenatal services through the Citizen/Alien Waivered-Emergency Medical program; and

(f) Clients receiving premium assistance through the Specified Low-Income Medicare Beneficiary, Qualified Individuals, Qualified Disabled Working Individuals and Qualified Medicare Beneficiary programs.

(18) The following populations are exempt from CCO enrollment until specified below:

(a) From August 1, 2012, until November 1, 2012, children under 19 years of age who are medically fragile and who have special health care needs. Beginning November 1, 2012, the Authority may enroll these children in CCOs on a case-by-case basis;

(b) Women who are in their third trimester of pregnancy when first determined eligible for OHP or at re-determination may qualify as identified below to receive OHP benefits on a Fee-for-Service (FFS) basis until 60 days after the birth of her child. After the 60 day period the OHP member must enroll in a CCO. In order to qualify for the FFS third trimester exemption the member must:

(A) Not have been enrolled with a service area CCO, FCHP or PCO during the three months preceding re-determination,

(B) Have an established relationship with a licensed qualified practitioner who is not a participating provider with the service area CCO, FCHP or PCO and wishes to continue obtaining maternity services from the non-participating provider on a FFS basis, and

(C) Make a request to change to FFS prior to the date of the delivery if enrolled with a CCO, FCHP or PCO.

(c) From August 1, 2012 until November 1, 2012, clients receiving health care services through the Breast and Cervical Cancer Program are exempt. Beginning November 1, 2012, enrollment is required;

(d) Existing clients who had organ transplants are exempt until the Authority enrolls them in a CCO on a case-by-case basis; and

(e) From August 1, 2012, until November 1, 2012, clients with end-stage renal disease. Beginning November 1, 2012, enrollment is required.

(19) The following clients who are exempt from CCO enrollment and who receive services on a fee-for-service basis may enroll in a CCO:

(a) Clients who are eligible for both Medicare and Medicaid;

(b) Clients who are American Indian and Alaskan Native beneficiaries;

(20) The Authority may exempt clients or temporarily exempt clients for other just causes as determined by the Authority through medical review. The Authority may set an exemption period on a case-by-case basis. Other just causes include the considerations:

(a) Enrollment would pose a serious health risk; and

(b) The Authority finds no reasonable alternatives.

(21) The following pertains to the effective date of the enrollment. If the enrollment occurs:

(a) On or before Wednesday, the date of enrollment shall be the following Monday; or

(b) After Wednesday, the date of enrollment shall be one week from the following Monday.

(22) Coordinated care services shall begin on the first day of enrollment with the CCO except for:

(a) A newborn's date of birth when the mother was a member of a CCO at the time of birth;

(b) For members who are re-enrolled within 30 calendar days of disenrollment, the date of enrollment shall be the date specified by the Authority that may be retroactive to the date of disenrollment;

(c) For adopted children or children placed in an adoptive placement, the date of enrollment shall be the date specified by the Authority.

Stat. Auth.: ORS 414.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 62-2012(Temp), f. 12-27-12, cert. ef. 1-1-13 thru 6-29-13; DMAP 4-2013(Temp), f. & cert. ef. 2-7-13 thru 6-29-13; DMAP 33-2013, f. & cert. ef. 6-27-13

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Rule Caption: Supported Employment Services definitions and Provider Requirements and Fidelity Reviews.
Adm. Order No.: DMAP 34-2013
Filed with Sec. of State: 6-27-2013
Certified to be Effective: 6-27-13

Notice Publication Date: 6-1-2013
Rules Amended: 410-141-3160
Subject: Supported employment services are delivered to individuals with serious mental illness to enable them to obtain and maintain employment. The requirements for providers that will deliver these services are being added to this rule. The rule informs CCOs what criteria and requirements the providers must comply with to receive reimbursement from the Authority and that the criteria and requirements may be found in the Addictions and Mental Health Division rules in chapter 309, division 16.

The chapter 309 rules set forth the fidelity review requirements and provide information on how these requirements may be accessed electronically.
Rules Coordinator: Cheryl Peters—(503) 945-6527

410-141-3160
Integration and Care Coordination

(1) In order to achieve the objectives of providing CCO members' integrated person centered care and services, CCOs must assure that physical, behavioral and oral health services are consistently provided to members in all age groups and all covered populations when medically appropriate and consistent with the needs identified in the community health assessment and community health improvement plan (Plan). CCOs must develop, implement and participate in activities supporting a continuum of care that integrates physical, behavioral, and oral health interventions in ways that are whole to the member and serve members in the most integrated setting appropriate to their needs:

(a) CCOs shall ensure the provision of care coordination, treatment engagement, preventive services, community based services, and follow up services for all members health conditions;

(b) CCOs must enter into contracts with providers of residential chemical dependency treatment services not later than July 1, 2013 and must notify the Authority within 30 calendar days of executing the contract;

(c) By July 1, 2014, each CCO must have a contractual relationship with any dental care organization that serves members in the area where they reside;

(d) CCOs must have adequate, timely and appropriate access to hospital and specialty services. CCOs must establish hospital and specialty service agreements that include the role of patient-centered primary care homes and that specify processes for requesting hospital admission or specialty services, performance expectations for communication and medical records sharing for specialty treatments, at the time of hospital admission or discharge, for after-hospital follow up appointments;

(e) CCOs must demonstrate how hospitals and specialty services will be accountable to achieve successful transitions of care. CCOs shall ensure members are transitioned out of hospital settings into the most appropriate independent and integrated community settings. This includes transitional services and supports for children, adolescents, and adults with serious behavioral health conditions facing admission to or discharge from acute psychiatric care, residential treatment settings and the state hospital.

(2) CCOs shall develop evidence-based or innovative strategies for use within their delivery system networks to ensure access to integrated and coordinated care, especially for members with intensive care coordination needs. CCOs must:

(a) Demonstrate that each member has a primary care provider or primary care team that is responsible for coordination of care and transitions and that each member has the option to choose a primary care provider of any eligible CCO participating provider type.

(b) Ensure that members with high health needs, multiple chronic conditions, or behavioral health issues are involved in accessing and managing appropriate preventive, health, behavioral health, remedial and supportive care and services;

(c) Use and require its provider network to use individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs, including members with severe and persistent mental illness receiving home and community based services covered under the state's 1915(1) State Plan Amendment, and those receiving DHS Medicaid-funded long-term care services. Plans should reflect member family, or caregiver preferences and goals to ensure engagement and satisfaction;

(d) Implement systems to assure and monitor improved transitions in care so that members receive comprehensive transitional care, and improve members' experience of care and outcomes, particularly for transitions between hospitals and long-term care;

(e) Demonstrate that participating providers have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion with members and their families or caregivers and to facilitate information exchange between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record capabilities);

(f) Work across provider networks to develop partnerships necessary to allow for access to and coordination with social and support services, including crisis management and community prevention and self-managed programs;

(g) Communicate its integration and coordination policies and procedures to participating providers, regularly monitor providers' compliance and take any corrective action necessary to ensure compliance. CCOs shall document all monitoring and corrective action activities.

(3) CCO's must assess the needs of its membership and make available supported employment and assertive community treatment services available when medically appropriate and when an appropriate provider is available. Appropriate providers are those that meet the requirements in 309-016-0825. When no appropriate provider is available, the CCO must consult with AMH and develop an approved plan to make supported employment and assertive community treatment services available.

(4) CCOs must develop and use Patient Centered Primary Care Home (PCPCH) capacity by implementing a network of PCPCHs to the maximum extent feasible:

(a) PCPCHs should become the focal point of coordinated and integrated care, so that members have a consistent and stable relationship with a care team responsible for comprehensive care management;

(b) CCOs must develop mechanisms that encourage providers to communicate and coordinate care with the PCPCH in a timely manner, using electronic health information technology, where available;

(c) CCOs must engage other primary care provider (PCP) models to be the primary point of care and care management for members, where there is insufficient PCPCH capacity;

(d) CCOs must develop services and supports for primary care that are geographically located as close as possible to the member's residence and are, if available, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations. CCOs shall ensure that all other services and supports are provided as close to the member's residence as possible.

(5) If a CCO implements other models of patient-centered primary health care in addition to the use of PCPCH, the CCO shall ensure member access to coordinated care services that provide effective wellness and prevention, coordination of care, active management and support of individuals with special health care needs, a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's physical and behavioral health care needs.

(6) If the member is living in a DHS Medicaid funded long-term care (LTC) nursing facility or community based care facility, or other residential facility, the CCO must communicate with the member and the DHS Medicaid funded long-term care provider or facility about integrated and coordinated care services:

(a) The CCO shall establish procedures for coordinating member health services, and how it will work with long-term care providers or facilities to develop partnerships necessary to allow for access to and coordination of CCO services with long-term care services and crisis management services;

(b) CCOs shall coordinate transitions to DHS Medicaid-funded long-term care by communicating with local AAA/APD offices when members are being discharged from an inpatient hospital stay, or transferred between different LTC settings;

(c) CCOs shall develop a Memorandum of Understanding (MOU) or contract with the local type B Area Agency on Aging or the local office of the Department's APD, detailing their system coordination agreements regarding members' receiving Medicaid-funded LTC services.

(7) For members who are discharged to post hospital extended care, at the time of admission to a skilled nursing facility (SNF) the CCO shall notify the appropriate AAA/APD office and begin appropriate discharge planning. The CCO shall pay for the post hospital extended care benefit if the member was a member of the CCO during the hospitalization preceding the nursing facility placement. The CCO shall notify the SNF and the member no later than two working days before discharge from post hospital extended care. For members who are discharged to Medicare Skilled Care, the CCO shall notify the appropriate AAA/APD office when the CCO learns of the admission.

(8) When a member's care is being transferred from one CCO to another or for OHP clients transferring from fee-for-service or PHP to a CCO, the CCO shall make every reasonable effort within the laws governing confidentiality to coordinate, including but not limited to ORS 414.679 transfer of the OHP client into the care of a CCO participating provider.

(9) CCOs shall establish agreements with the Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) operating in the service area, consistent with ORS 414.153, to maintain a comprehensive and coordinated behavioral health delivery system and to ensure member access to mental health services, some of which are not provided under the global budget.

(10) CCOs shall coordinate a member's care even when services or placements are outside the CCO service area. CCO assignment is based on the case member's residence, and referred to as county of origin or jurisdiction. Temporary placements by the Authority, Department or health services placements for services including residential placements may be located out of the service area, however, the CCO shall coordinate care while in placement and discharge planning for return to county of origin or jurisdiction. For out of area placements, an out of area exception must be made for the member to retain the CCO enrollment in the county of origin or jurisdiction, while the member's placement is a temporary residential placement elsewhere. For program placements in Child Welfare, BRS, OYA, and PTRS, refer to OAR 410-141-3050 for program specific rules.

(11) CCOs shall ensure that members receiving services from extended or long-term psychiatric care programs such as secure residential facilities, PASSAGES projects, or state hospital, shall receive follow-up services as medically appropriate to ensure discharge within five working days of receipt of notice of discharge readiness.

(12) CCOs shall coordinate with Community Emergency Service Agencies, including but not limited to police, courts, juvenile justice, corrections, LMHAs and CMHPs, to promote an appropriate response to members experiencing a behavioral health crisis and to prevent inappropriate use of the emergency department or jails.

(13) CCOs shall accept FFS authorized services, medical, and pharmacy prior authorizations, ongoing services where a FFS prior authorization is not required, and services authorized by the Division's Medical Management Review Committee for 90 days, or until the CCO can establish a relationship with the member and develop an evidence based, medically appropriate coordinated care plan, whichever is later, except where customized equipment, services, procedures, or treatment protocol require service continuation for no less than six months.

(14) Except as provided in OAR 410-141-3050, CCOs shall coordinate patient care, including care required by temporary residential placement outside the CCO service area, or out-of-state care in instances where medically necessary specialty care is not available in Oregon:

(a) CCO enrollment shall be maintained in the county of origin with the expectation of the CCO to coordinate care with the out of area placement and local providers;

(b) The CCO shall coordinate the discharge planning when the member returns to the county of origin.

(15) CCOs shall coordinate and authorize care, including instances where the member's medically appropriate care requires services and providers outside the CCO's contracted network, in another area, out-of-state, or a unique provider specialty not otherwise contracted. The CCO shall pay the services and treatment plan as a non-participating provider pursuant to OAR 410-120-1295.

Stat. Auth.: ORS 413.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610–414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 1-2013(Temp), f. & cert. ef. 1-4-13 thru 7-2-13; DMAP 34-2013, f. & cert. ef. 6-27-13

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Rule Caption: Change method of payment to FQHC and RHC Out Station Outreach Worker Activities
Adm. Order No.: DMAP 35-2013
Filed with Sec. of State: 6-27-2013
Certified to be Effective: 6-27-13
Notice Publication Date: 6-1-2013
Rules Amended: 410-147-0400
Subject: The Division needs to amend 410-147-0400 to change the method of payment to Federally Qualified Health Clinics (FQHC) and Rural Health Clinics (RHC) for out stationed outreach worker activities. These clinics have historically been reimbursed for out stationed outreach worker activities through a rate calculated from 100% of cost, which was then added to their base Prospective Payment System (PPS) all inclusive encounter rate, This amended rule will reimburse clinics 100% of their allowable costs for out stationed outreach worker activities and be paid in four equal installments at the beginning of each calendar quarter, January 1, April 1, July 1, and October 1.
Rules Coordinator: Cheryl Peters—(503) 945-6527

410-147-0400
Compensation for Outstationed Outreach Activities

(1) This rule provides reasonable compensation for activities directly related to the receipt and initial processing of applications for individuals, including low-income pregnant women and children, to apply for Medicaid at outstation locations other than state offices.

(2) A federally qualified health center (FQHC) eligible in accordance with OAR 410-120-0045, will be eligible for compensation under this rule.

(3) ''Initial processing'' includes the following activities:

(a) Taking applications;

(b) Assisting applicants in completing the application;

(c) Providing information as outlined in OAR 410-120-0045;

(d) Obtaining required documentation to complete processing of the application;

(e) Ensuring that the information contained on the application form is complete; and

(f) Conducting any necessary interviews.

(4) "Initial processing" does not include evaluating the information contained on the application and the supporting documentation or making a determination of eligibility or ineligibility.

(5) At locations that are infrequently used by the designated low-income eligibility groups, the Division may use the following resources:

(a) Volunteers, provider or contractor employees; or

(b) Its own eligibility staff, or

(c) Telephone assistance by:

(A) The FQHC as outlined in section (12); or

(B) Prominently displaying a notice that includes the telephone number for the state OHP Application Center or the local branch office that applicants may call for assistance.

(6) Eligible FQHCs may be able to receive reasonable compensation for outreach activities performed by Outstationed Outreach Workers (OSOW) that is equal to 100% of direct costs.

(7) Allowable direct cost expenses for OSOW reimbursement include:

(a) Travel expenses incurred by the FQHC for Division training on OSOW activities;

(b) Phone bills, if a dedicated line is used. Otherwise an estimate of telephone usage and resulting costs;

(c) OSOW personnel costs:

(A) Wages shall be the lesser of:

(i) Wages reported by the FQHC; or

(ii) Wages paid by the State of Oregon to an employee of the state providing enrollment assistance to individuals applying for OHP;

(iii) Wage reimbursement may not exceed the highest salary issued by the State of Oregon to a Human Services Specialist 2;

(B) Taxes;

(C) Fringe benefits provided to OSOW;

(D) Premiums paid by the FQHC for private health insurance.

(d) Reasonable costs for equipment necessary to perform outreach activities, which does include expenses for replacing equipment if the original equipment cost was reported on the cost statement when the clinic's initial PPS encounter rate was calculated;

(e) Rent or space costs only if 100% of facility costs were not reported on the cost statement when the clinic's initial PPS encounter rate was calculated;

(f) Reasonable office supplies necessary to perform outreach activities; and

(g) Postage.

(8) The Division may not include indirect costs in the OSOW reimbursement rate. Indirect costs include but are not limited to the following:

(a) Any costs included in the initial calculation of a clinic's PPS encounter rate;

(b) Contracted interpretation services;

(c) Administrative overhead costs;

(d) Supervision costs; and

(e) Operating expenses including utilities, building maintenance and repair, and janitorial services.

(9) Clinics must submit to the Division a cost statement for the preceding calendar year between October 1, and October 31, of each year for Division review and approval of the clinic's OSOW direct costs.

(10) If a clinic fails to submit the OSOW cost statement by October 31 of the required year, the clinic may not be eligible for reimbursement of OSOW costs as of January 1 for the following year.

(11) Any change to the OSOW rate, based on the October cost statement submission, shall be effective January 1 of the following year; The Division shall make payment to the clinic for the reviewed and accepted OSOW costs in four equal installments at the beginning of each calendar quarter; January 1, April 1, July 1, and October 1.

(12) Clinic locations with limited operating hours, or that limit access to the general public during their regular operating hours must calculate the actual time an OSOW meets face-to-face with the general public for receipt and the initial processing of applications. For example, if a clinic employs an OSOW at a satellite school-based health center (SBHC), and the SBHC can only be accessed by the general public outside of the school's normal hours of operation, use the percent of time an OSOW is available to meet face-to-face with potential applicants when reporting compensation as outlined in section (11)(c) of this rule.

(a) Clinics must display a notice in a prominent place that advises potential applicants when an OSOW will be available;

(b) The notice must include a telephone number that applicants may call for assistance.

(13) For staff employed by a clinic and performing outreach activities at less than full time, the clinic must calculate the percentage of time spent performing OSOW activities and maintain adequate documentation to support the time claimed. The percentage must be used to calculate personnel expenses incurred by an FQHC that are directly attributed to outreach activities performed by the employee. Outreach activities:

(a) May include assisting individuals with completing applications for other Department of Human Services (Department) and Authority-administered programs where eligibility is determined by staff at local branch offices;

(b) Does not include assisting individuals with applying for non-Department and non-Authority-administered programs.

(14) A clinic shall not claim reimbursement for costs associated with personnel positions where 100% of costs were included in the FQHC's PPS encounter rate calculation.

(15) A Public Health Department designated as an FQHC or a School Based Health Center (SBHC) within the scope of an FQHC designation cannot participate in the Medicaid Administrative Claiming (MAC) program.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 13-1993, f. & cert. ef. 71-1-93; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0330; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 47-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 8-2011, f. 6-6-11, cert. ef. 7-1-11; DMAP 64-2012(Temp), f. 12-27-12, cert. ef. 1-1-13 thru 6-29-13; DMAP 9-2013(Temp), f. & cert. ef. 3-1-13 thru 6-29-13; DMAP 35-2013, f. & cert. ef. 6-27-13

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Rule Caption: Medical Transportation for Recipients of Medical Assistance Programs
Adm. Order No.: DMAP 36-2013
Filed with Sec. of State: 6-27-2013
Certified to be Effective: 7-1-13
Notice Publication Date: 5-1-2013
Rules Adopted: 410-136-3000, 410-136-3020, 410-136-3040, 410-136-3060, 410-136-3080, 410-136-3100, 410-136-3120, 410-136-3140, 410-136-3160, 410-136-3180, 410-136-3200, 410-136-3220, 410-136-3240, 410-136-3260, 410-136-3280, 410-136-3300, 410-136-3320, 410-136-3340, 410-136-3360
Rules Repealed: 410-136-0030, 410-136-0040, 410-136-0045, 410-136-0050, 410-136-0060, 410-136-0070, 410-136-0080, 410-136-0100, 410-136-0120, 410-136-0140, 410-136-0160, 410-136-0180, 410-136-0200, 410-136-0220, 410-136-0240, 410-136-0245, 410-136-0260, 410-136-0280, 410-136-0300, 410-136-0320, 410-136-0340, 410-136-0350, 410-136-0360, 410-136-0420, 410-136-0440, 410-136-0800, 410-136-0820, 410-136-0840, 410-136-0860
Subject: These rules establish the requirements for transportation brokerages and the Authority to coordinate and pay for the delivery of medical transportation for OHP recipients to and from locations providing OHP covered medical services.
Rules Coordinator: Cheryl Peters—(503) 945-6527

410-136-3000
Responsibility for Providing Non-emergent Medical Transportation

(1) The Authority shall provide non-emergent medical transportation (NEMT) for eligible clients who receive their OHP covered medical services on a fee-for-service basis or are members enrolled in prepaid health plans (PHP) or coordinated care organizations (CCO). The Authority shall cease providing this service to CCO enrollees when CCOs provide the service to their enrollees pursuant to sections (2) and (3) of this rule.

(2) From July 1, 2013 to October 1, 2013, the Authority may allow some CCOs to pilot providing NEMT services for their enrollees.

(3) All CCOs shall provide NEMT services for their enrollees either on October 1, 2013, or January 1, 2014. When a CCO begins providing this service, the Authority shall provide NEMT services in the CCO's service area only to clients not enrolled in a CCO for health care services.

(4) The requirements in OAR 410-136-3020 – OAR 410-136-3360 apply to NEMT services for which the Authority is responsible pursuant to this rule.

(5) A brokerage may request that the Authority delay responsibility for reimbursement to clients pursuant to OAR 410-136-3240, Client Reimbursed Mileage, Meals and Lodging, until a CCO in the brokerage's service area assumes NEMT services for the CCO's enrollees (either October 2013 or January 1, 2014).. The delay of the brokerage's responsibility also includes reimbursing clients in the fee-for-service delivery system.

(6) OAR 410-136-3040,Vehicle Equipment and Subcontractor Standards, and 410-136-3120, Secured Transports, do not apply to ambulance providers, ambulance vehicles or ambulance personnel that are licensed and regulated by ORS Chapter 682 and OAR chapter 333, divisions 250, 255, 260 and 265, whether providing ambulance or stretcher transports.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3020
General Requirements for NEMT

(1) The Authority may enroll governmental transportation brokerages (local units of government) or other entities to arrange rides and pay subcontractors for NEMT services. The Authority may limit the enrollment with brokerages to units of local government.

(2) For purposes of the rules (OAR 410-136-3020 through 410-136-3360), "subcontractor" means the individual or entity with which the brokerage subcontracts or employs to drive the client to and from OHP covered medical services.

(3) The brokerage shall:

(a) Prior authorize and pay subcontractors for the least costly but most appropriate mode of transport for the client's medical needs to and from an OHP covered medical service. The most appropriate and least costly ride may include requiring the client to share the ride with other clients;

(b) Verify that the client is obtaining OHP covered medical services in the client's local area. "Local area" means an area within the accepted community standard and includes the client's metropolitan area, city or town of residence;

(c) Verify the client's OHP eligibility and that the client's benefit package includes NEMT services. The brokerage shall verify this through electronic eligibility information;

(d) Assess the client's access to other means of transportation, such as driving their own car or getting a ride from a family member or neighbor;

(e) Verify the client's attendance for continuing requests for rides if the medical provider could not affirm an appointment for a previous ride;

(f) Schedule a ride with an alternate subcontractor if the subcontractor originally assigned is unable to provide the ride; and

(g) Assign rides based on an evaluation of several factors, including but not limited to:

(A) Cost;

(B) The client's need for appropriate equipment and transportation;

(C) Any factors related to a subcontractor's capabilities, availability and past performance; and

(D) Any factors related to the brokerage's need to maintain sufficient service capacity to meet client needs.

(4) Pursuant to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System, clients receiving the following benefit packages are not eligible for NEMT:

(a) OHP Standard;

(b) Citizen Alien Waived Emergency Medical; and

(c) Qualified Medicare Beneficiary (QMB) only.

(5) The brokerage shall maintain records of the reasons for authorizing a ride:

(a) That is not cost effective or not based on the factors specified in section (3);

(b) With more than two attendants for an ambulance or stretcher car; or

(c) With more than one attendant for a wheelchair van.

(6) The brokerage shall provide a ride to a client to fill prescription medication only in the following situation:

(a) The client needs to stop on the way home to fill or pick up prescribed medication related to the medical service for which the brokerage provided the ride;

(b) It is medically necessary to fill or pick up the medication immediately; and

(c) The pharmacy is located on the return route or is the closest pharmacy to the return route.

(7) The brokerage may provide a ride to a client to fill prescribed medication under the following situations:

(a) The brokerage asks the client if the prescription service is available through the Authority's contracted postal prescription service, and the client responds that it is not available through that source;

(b) The client has an urgent need to fill or pick up prescribed medication because the postal prescription service mailed the wrong medication, or the client has an unexpected problem caused by the medication; or

(c) The client is transient or without regular access to a mailbox. In this situation, the brokerage may evaluate the need on a case-by-case basis.

(8) The brokerage shall provide rides outside the brokerage's service area, as described in Table 136-3380, under the following circumstances:

(a) The client is receiving an OHP covered medical service that is not available in the service or local area but is available in another area of the state;

(b) The client is receiving a covered service in California, Idaho or Washington where the service location is no more than 75 miles from the Oregon border; or

(c) No local medical provider or facility will provide OHP covered medical services for the client.

(9) Brokerages may coordinate to provide a return ride to a client who receives medical services outside the client's local area.

(10) Brokerages shall retroactively authorize and pay for NEMT services that have already occurred only when the brokerage could not prior authorize the service because the brokerage was closed and the request for authorization is within 30 days of the date of service. The brokerage also must confirm that one of the following circumstances supported the ride:

(a) The eligible client needed urgent medical care;

(b) The eligible client required secured transport pursuant to OAR 410-136-3120, Secured Transports; or

(c) The client was in a hospital, and the hospital discharged or transferred the client.

(11) Notwithstanding section (10), a brokerage shall retroactively authorize NEMT services for ambulance transports when:

(a) An ambulance provider responds to an emergency call, but the client's medical condition does not warrant an emergency transport;

(b) The ambulance provider transports the client as a NEMT service; and

(c) The ambulance provider requests retroactive authorization within 30 days of the NEMT service.

(12) Brokerages shall not authorize or pay for rides outside their service areas based only on client preference or convenience.

(13) Brokerages shall provide toll-free call centers for clients to request rides. The following pertain to the brokerage's call center and scheduling of rides:

(a) The call center shall operate at a minimum Monday through Friday from 9:00 am to 5:00 pm, but the brokerage may close the call center on New Year's Day, Memorial Day, July 4, Labor Day, Thanksgiving and Christmas. The Authority may approve, in writing, additional days of closure if the brokerage requests the closure at least thirty days in advance.

(b) Brokerages shall make all reasonable efforts for clients to have access to available NEMT services 24 hours a day. When the call center is closed, the brokerages shall provide a recording or answering service to refer the client directly to a subcontractor. If no subcontractor is available, the brokerage must provide clients with recorded information about service hours and how to reach emergency services by calling 911;

(c) The brokerage shall allow a client to schedule rides at least 30 days in advance of the medical service; and

(d) The brokerage shall allow a client to request multiple ride requests at one time.

(e) The brokerage shall develop procedures and make reasonable efforts to arrange a ride requested on the day of the medical service when the medical service is:

(A) For an urgent medical condition; and

(B) Due to the urgency of the medical condition, the client scheduled an immediate medical appointment.

(14) The brokerage is not responsible for providing emergency medical transportation services. However, brokerages shall have procedures for referring clients requesting emergency medical transportation services to the appropriate emergency transportation resources and procedures for subcontractors per OAR 410-136-3040, Vehicle Equipment and Subcontractor Standards.

(15) The Authority shall collaborate with brokerages to develop and conduct a statewide client satisfaction survey at least once every two years. The Authority may contract with one or more brokerages to conduct the survey. The Authority shall use the results of the survey to identify and address potential operational deficiencies and to identify and share successes in the NEMT program.

(16) Brokerages shall establish regional advisory groups consisting of representatives from the Authority, DHS, Area Agencies on Aging, consumers. representatives of client advocacy groups from within the service or local area, brokerage subcontractors and providers of NEMT ambulance services. The role of the group includes, but is not limited to:

(a) Assisting in monitoring and evaluating the NEMT program; and

(b) Recommending potential policy or procedure changes and program improvements to brokerages and the Authority and assisting in prioritizing those changes and improvements.

(17) Brokerages shall have the discretion to use or not use DHS-approved volunteers. DHS shall provide brokerages with a list of approved and trained volunteers. DHS shall supervise the volunteers and assumes all liability for each volunteer as provided by law.

(18) Brokerages or their subcontractors shall not bill eligible clients for any transports to and from OHP covered medical services or any transports where the Authority denied reimbursement.

(19) On a minimum of five percent of the ride requests, brokerages shall contact medical providers to verify appointments and that the appointments are for OHP covered medical services.

(20) Brokerages may purchase tickets for common carrier transportation, such as inter- or intra-city bus, train or commercial airline when deemed cost effective and safe for the client.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3040
Vehicle Equipment and Subcontractor Standards

(1) Brokerages shall require subcontractors to maintain their vehicles for the comfort and safety of the clients. The vehicles shall meet the following requirements:

(a) The interior of the vehicle shall be clean;

(b) The subcontractor shall not smoke or permit smoking in the vehicle at any time; and

(c) The subcontractor shall comply with appropriate local, state, and federal transportation safety standards regarding passenger safety and comfort. The vehicle shall include, but is not limited to, the following safety equipment:

(A) Safety belts for all passengers if the vehicle is legally required to provide safety belts;

(B) A first aid kit;

(C) A fire extinguisher;

(D) Roadside reflective or warning devices;

(E) A flashlight;

(F) Tire traction devices when appropriate;

(G) Disposable gloves; and

(H) All equipment necessary to transport clients using wheelchairs or stretchers if the subcontractor uses the vehicle for these modes of transport.

(2) The subcontractor shall follow a preventative maintenance schedule that incorporates at least all of the maintenance recommended by the

vehicle manufacturer. The vehicle must be in good operating condition and shall include, but is not limited to:

(a) Side and rear view mirrors;

(b) A horn; and

(c) Working turn signals, headlights, taillights and windshield wipers.

(3) Brokerages shall require the subcontractors' drivers to receive training on their job duties and responsibilities, including:

(a) Understanding NEMT services in general, reporting forms, vehicle operation, requirements for fraud and abuse reporting and the geographic area in which subcontractors will provide service;

(b) Requiring the subcontractors' drivers to complete the National Safety Council Defensive Driving course or an equivalent course within six months of the date of hire and at least every three years thereafter;

(c) Requiring the subcontractors' drivers to complete Red Cross-approved First Aid, Cardiopulmonary Resuscitation and blood spill procedures courses or equivalent courses within six months of the date of hire and to maintain the certification as a condition of employment;

(d) Requiring the subcontractors' drivers to complete the Passenger Service and Safety course or an equivalent course within six months of the date of hire and at least every three years thereafter;

(e) Understanding established procedures for subcontractors and the subcontractors' drivers in the event that the client needs emergency care during the ride; and

(f) If providing ground or air ambulance services, verifying that the Authority has licensed the subcontractor to operate ground or air ambulance. If the subcontractor is located in a contiguous state and regularly provides rides to OHP eligible clients, the brokerage must ensure that both the Authority and the contiguous state have licensed the subcontractor.

(4) Brokerages shall require the following when hiring a subcontractor:

(a) The subcontractor's driver must have valid driver license. The license must be the class of license, with any required endorsements, that permits the subcontractor's driver to legally operate the vehicle for which they are hired to drive per ORS Chapter 807 and OAR chapter 735, division 062, or the applicable statutes of other states; and

(b) The subcontractor's drivers must pass a criminal background check in accordance with ORS 181.534 and 181.537 and OAR chapter 257, division 10, or if the brokerage is a mass transit district formed under ORS Chapter 267, the subcontractor's drivers must pass a criminal background check in accordance with ORS 267.237 and the mass transit district's background check policies. The brokerage may request an exception to this requirement in writing to the Authority, but only the Authority may grant the exception. Approval of the exception is dependent upon when the crime occurred, the nature of the offense, and any other circumstances to ensure that the client is not at risk of harm from the subcontractor. If approved, the Authority shall document the approval within 30 days of the request.

(5) For authorized out-of-state NEMT services in which the subcontractor solely performs work in the other state and for which the brokerage has no oversight authority, the brokerage is not responsible for requiring that the subcontractor's vehicle and the subcontractor's standards meet the requirements set forth in this rule.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3060
Insurance Requirements

(1) Brokerages must obtain and maintain general and automobile liability coverage for personal injury and death in accordance with ORS 30.271, Limitations on Liability of State for Personal Injury and Death.

(2) Brokerages must obtain and maintain general and automobile liability coverage for property damage and destruction in accordance with ORS 30.273, Limitations on Liability of Public Bodies for Property Damage or Destruction.

(3) The liability coverage required by sections (1) and (2) of this rule shall include the State of Oregon, Oregon Health Authority and its divisions, officers, employees and agents as additional insureds but only as related to the brokerages' NEMT services.

(4) In lieu of purchasing liability coverage under sections (1) and (2) of this rule, the Authority may authorize a brokerage to establish and maintain a Self-Insurance Reserve Fund. The following apply to requirements of the fund:

(a) The Authority shall establish the fund at $1,000,000 through the fixed rate for rides established in OAR 410-136-3200, Reimbursement and Accounting for all Modes of Transport;

(b) The fund shall comply with OMB Circular 87;

(c) If the brokerage subsequently terminates its enrollment with the state as a Medicaid provider, the brokerage shall refund the Authority the balance of any monies in the fund within two years from the termination of its enrollment or at the conclusion of any claim or litigation related to the brokerage's NEMT services for eligible clients;

(d) Once funded, the fund shall be maintained at an amount not less than $1,000,000 through the fixed rate for rides established in OAR 410-136-3200, Reimbursement and Accounting for all Modes of Transport;

(e) The Authority shall reconcile the fund amount during the annual cost settlement process pursuant to Oar 410-136-3200, Reimbursement and Accounting for all Modes of Transport, and shall increase or decrease the fixed rate for ride to maintain the $1,000,000 fund amount; and

(f) The brokerage shall maintain a separate account for the fund.

(5) Brokerages and their subcontractors that employ workers as defined in ORS 656.027 shall comply with 656.017 and shall provide workers' compensation insurance coverage for those workers, unless they meet the requirement for an exemption under 656.126 (2). Brokerages shall require each of their subcontractors to comply with this requirement.

(6) In lieu of purchasing workers' compensation insurance coverage as required by section (5), a brokerage may self-insure for all of its subject workers. The Authority shall not fund this reserve and shall only reimburse the brokerage for costs of self-insurance in the event of a claim arising from the brokerage's NEMT services to eligible clients.

(7) Brokerages and their subcontractors shall furnish proof of liability coverage and insurance to the Authority upon request.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3080
Out-of-State Transportation

(1) "Out-of-state transportation" means transportation to or from any location outside Oregon, with the exception of contiguous areas up to 75 miles outside the Oregon border.

(2) The brokerage shall arrange rides and pay for out-of-state transportation, as defined in section (1) of this rule, to and from an out-of-state OHP covered medical service when:

(a) The brokerage confirms that the Authority, the Prepaid Health Plan (PHP) or CCO authorized the out-of-state OHP covered medical service per OAR 410-120-1180, Medical Assistance Benefits: Out-of-State Services; and

(b) The client is eligible for transportation services per OAR 410-136-3020, General Requirements for NEMT.

(3) Brokerages shall not arrange or pay for:

(a) A client's return from any foreign country to any location within the United States for the client to obtain medical care because the care is not available in the foreign country;

(b) A client's return to Oregon from another state when the client was not in the other state to obtain authorized medical services or treatments.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3100
Attendants for Child Transports

(1) This rule applies to NEMT for children under 12 years of age who are eligible for NEMT services to and from OHP covered medical services. The rule also applies to children and young adults with special physical or developmental needs, regardless of age, hereafter referred to as "child" or "children."

(2) Parents or legal guardians must provide an attendant to accompany the children while traveling to and from medical appointments except when:

(a) The driver is a DHS volunteer, DHS employee or an Authority employee;

(b) The child requires secured transport per OAR 410-136-3120, Secured Transports; or

(c) An ambulance subcontractor transports the child for NEMT services, and the brokerage reimburses the ambulance subcontractor at the ambulance transport rate.

(3) Attendants are required for NEMT ambulance transports when the brokerage uses an ambulance to provide wheelchair or stretcher car or van rides.

(4) DHS shall establish and administer written guidelines for children in the department's custody, including written guidelines for volunteer drivers. If DHS's requirements or administrative rules differ from this rule, DHS's requirements or administrative rules take precedence.

(5) An attendant may be the mother, father, stepmother, stepfather, grandparent or legal guardian of the child. The attendant also may be any adult the parent or legal guardian authorizes to be an attendant. An attendant also may be a brother, sister, stepbrother or stepsister of the child, as long as the attendant is at least 18 years of age, and the parent or legal guardian authorizes it.

(6) Brokerages or their subcontractors may require the child's parent or legal guardian to provide written authorization for an attendant other than themselves to accompany the child.

(7) Brokerages or their subcontractors shall not bill additional charges for a child's attendant.

(8) The attendant must accompany the child from the pick-up location to the destination and on the return trip. The attendant must also remain with the child during their appointment. Another person shall not accompany the attendant unless the parent or legal guardian authorizes it or unless the other person is an eligible child traveling to the same location for a medical appointment.

(9) The parent, guardian or adult caregiver for the child shall provide and install child safety seats as required by state law. The subcontractor shall not transport a child if a parent or legal guardian fails to provide a child safety seat that complies with state law.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3120
Secured Transports

(1) "Secured transport" means NEMT services for the involuntary transport of clients who are in danger of harming themselves or others. Secured transports are allowable when:

(a) The brokerage verified that the subcontractor has met the requirements of the secured transport protocol pursuant to OAR 309-033-0200 through 309-033-0970, and, therefore, the subcontractor is able to transport the client who is in crisis or at immediate risk of harming themselves or others due to mental or emotional problems or substance abuse; and

(b) The transport is to a Medicaid enrolled facility that the Authority recognizes as being able to treat the immediate medical or behavioral health care needs of the client in crisis.

(2) One additional attendant may accompany the client at no additional charge when medically appropriate, such as to administer medications, etc. in-route, or to satisfy legal requirements, including, but not limited to when a parent, legal guardian or escort is required during transport.

(3) The brokerage shall authorize transports to and from OHP covered medical services for an eligible client when the court orders the medical service with the following exceptions:

(a) The client is in the custody of or under the legal jurisdiction of any law enforcement agency;

(b) The client is an inmate of a public institution as defined in OAR 461-135-0950, Eligibility for Inmates; or

(c) The Authority has suspended the client's OHP eligibility pursuant to ORS 414.420 or 414.424.

(4) The brokerage shall assume that a client returning to their place of residence is no longer in crisis or at immediate risk of harming themselves or others, and is, therefore, able to use non-secured transportation. In the event that a secured transport is medically appropriate to return a client to their place of residence, the brokerage shall obtain written documentation, signed by the treating medical professional, stating the circumstances that required secured transport. The brokerage shall retain the documentation and a copy of the order in their record for the Authority to review.

(5) The brokerage shall not approve or pay for secured medical transport provided to a person going to or from a court hearing or to or from a commitment hearing.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3140
Transports of Clients Changing Hospitals or Other Facilities

(1) Brokerages shall arrange and pay for transporting an eligible client who has had a change in condition, noted in the client's DHS care plan, resulting in a need for a new service setting with a lower or higher level of care. This includes clients who are changing levels of care between their community-based care settings or between institutional and community-based settings. The client's DHS worker must request the ride.

(2) Brokerages shall not arrange or pay for:

(a) The transport or return of an inpatient client from an admitting hospital to another hospital (or facility) for diagnostic or other short-term services when the patient will return to the admitting hospital within the first 24-hours of admission. The subcontractor shall bill the admitting hospital directly for these transports;

(b) The transport of a client receiving long-term care service in their home or residing in a long-term care facility for the sole purpose of shopping for another long-term care facility, even if the client is looking for a new facility to receive a lower or higher level of care;

(c) The transport of a client moving from one type of facility to a facility of the same type, such as from an adult foster home to another adult foster home; and

(d) The transport of a client who is relocating to another state, unless the transport is to receive an OHP covered medical service pursuant to ORS 410-136-3080, Out-of-State Transportation.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3160
Ground and Air Ambulance Transports

(1) Transporting a client via ambulance is required when a medical facility or provider states the client's medical condition requires the presence of a health care professional during the emergency or non-emergency transport. This includes neonatal transports.

(2) For NEMT services, the brokerage shall authorize the transport.

(3) Brokerages shall provide ambulance transports with a medical technician when:

(a) A client's medical condition requires a stretcher;

(b) The length of transport would require a personal care attendant; and

(c) The client does not have an attendant who can assist with personal care during the ride.

(4) Emergency ambulance transportation is required when a client's medical condition is an emergency pursuant to OAR 410-120-0000, Acronyms and Definitions. The ambulance must transport the client to the nearest appropriate facility able to meet the client's medical needs. Brokerages do not arrange emergency transportation.

(5) The following apply to air-ambulance NEMT services:

(a) The brokerage shall approve air-ambulance NEMT only when another mode of transportation would further jeopardize or compromise the client's medical condition due to:

(A) The length of time required to transport the client by ground-ambulance;

(B) Current road conditions preclude the use of ground transportation; or

(C) Ground-ambulance is not available.

(b) Notwithstanding section (4) (a), the brokerage may grant air-ambulance transportation if it determines the transportation is cost effective. The brokerage shall document how air-ambulance is more cost effective than ground transportation.

(c) The brokerage must obtain a written recommendation from the client's medical provider indicating medical appropriateness before authorizing air-ambulance transportation.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3180
Reimbursement for Ground and Air Ambulance Transports

(1) The following applies to how the Authority shall reimburse providers of NEMT ground and air ambulance services that brokerages arrange for eligible clients. This applies to clients receiving services through the fee-for-service delivery system, a PHP or a CCO.

(2) Brokerages shall submit documentation to the Authority stating the brokerage authorized the transportation. The documentation also shall inform the Authority to reimburse at the Authority's base rate or another amount the brokerage specifies. Ambulance providers shall bill the Authority for payment of authorized rides.

(3) If brokerage does not specify another amount, the Authority's reimbursement shall include:

(a) The base rate established in the Authority's fee schedule posted on the OHP Web page at http://www.oregon.gov/oha/healthplan/pages/data_pubs/feeschedule/main.aspx. The base rate for NEMT ground and air ambulances includes:

(A) Any procedures or services provided, all medications, non-reusable supplies or oxygen and all direct or indirect costs. "Indirect costs" include general operating costs, personnel costs, neonatal intensive care teams employed by the ambulance subcontractor, use of reusable equip-

ment and any other miscellaneous medical items or special handling that may be required in the course of transport;

(B) The first ten miles for ground ambulance transports; and

(C) Mileage for air ambulance transports.

(b) A modified base rate for each additional client, according to OAR 410-136-3220, Brokerage Reimbursements to Subcontractors, if applicable;

(c) Payment for an extra attendant, if applicable; and

(d) Compensation for service or care provided at the scene when the client did not require transport, if applicable.

(4) Reimbursement outlined in section (3) also applies to the Authority's reimbursements to providers of emergency ground or air ambulance services for clients who receive services through the fee-for-service delivery system.

(5) A PHP is responsible for reimbursement to providers of emergency ground or air ambulance for clients who are PHP members.

(6) A CCO is responsible for reimbursement to providers of emergency ground or air ambulance for clients who are CCO enrollees.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3200
Reimbursement and Accounting for all Modes of Transports

(1) The following applies to the rate the Authority pays brokerages:

(a) The Authority shall calculate and pay a brokerage a fixed rate for rides based on the following formula: Direct costs plus indirect costs divided by the number of projected monthly rides. "Direct costs" are transportation costs plus administrative costs;

(b) The Authority shall notify the brokerages of their specific ride rates; and

(c) The Authority and the brokerages shall assess any needed modifications to this rate:

(A) Quarterly;

(B) When the Authority changes any program affecting eligibility or scope; or

(C) If other factors impact the cost of delivering service.

(2) Brokerages shall account for NEMT services separate from any other services the brokerage provides.

(3) The Authority shall reimburse brokerages after they submit claims data files to the Authority, using the standardized electronic billing format prescribed by the Authority.

(4) The Authority and brokerages shall conduct an annual cost settlement to determine any overpayment or underpayment for costs the brokerage incurred for NEMT services for eligible clients. The following applies to the cost settlement process:

(a) The Authority shall request cost settlement information from the brokerages 6 months after the end of the fiscal year. The request shall include a file detailing the brokerages claims, a template for the brokerages to submit their cost settlement information and instructions for completing the template;

(b) Brokerages shall submit the requested information, certified by a Certified Public Accountant, within 90 days of receiving the Authority's request;

(c) The Authority shall verify the reported expenses and notify the brokerages in writing of the Authority's determination;

(d) If the Authority's determination results in an adjustment to the cost settlement information the brokerages submitted, the brokerages may request an appeal pursuant to OAR 410-120-1560 through 410-120-1700, pertaining to provider appeals.

(5) The Authority shall pay for services the brokerage authorized and provided in good faith, including mailing transit passes to clients. The Authority shall use the rate in effect on the day of the transport or the mailing date of the transit passes. "Good faith" means:

(a) The brokerage verified client eligibility on the date of service or the date of mailing the transit passes, using the Authority's eligibility information; or

(b) The client eligibility information was inconsistent or not available, and the brokerage used the most recent client information available immediately before the time of service or mailing of transit passes.

(6) Each brokerage may establish a working capital reserve with funds the Authority provides. The following applies to any established working capital reserve:

(a) The working capital reserve shall represent 30 days of cash expenses for normal operating purposes. The Authority may base the reserve on a time other than 30 days if circumstances warrant the change;

(b) The Authority shall calculate the reserve amount as part of the annual cost settlement for the most recent past fiscal year;

(c) The Authority shall base the reserve amount on an average of six months of operating expenses that the brokerage reports in its monthly NEMT financial reports. However, the Authority may base the reserve amount on more or less than six months of expenses when a six-month average does not reflect an accurate accounting of expenses;

(d) Brokerages shall maintain a separate account for the reserve funds; and

(e) The Authority may require the brokerage to return any funds in excess of the amount the Authority calculated, or the Authority may decrease the ride rate to reduce the reserves. If the Authority requires the brokerage to return the excess funds, the brokerage shall do so within 45 days of receipt of the Authority notification.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3220
Brokerage Reimbursements to Subcontractors

(1) Brokerages shall reimburse their NEMT subcontractors for the most cost-effective route from point of origin to point of destination that most benefits the client's condition.

(2) Brokerages shall establish a base rate with its subcontractors. "Base rate" for all modes of transportation except ground and air ambulance means the rate the brokerage and its subcontractors agree on for each mode of transportation.

(3) If a subcontractor uses an ambulance as a stretcher car or van, the brokerage shall reimburse the subcontractor using the base rate for stretcher cars or vans.

(4) Notwithstanding section (3), brokerages shall pay ambulance subcontractors at the ambulance rate instead of the stretcher car or van rate when the transport exceeds two hours, necessitating a health care professional to care for the client during the ride.

(5) Brokerages shall not reimburse their subcontractors for waiting for clients to get to the vehicle or for assisting clients to get in or out of a vehicle.

(6) Brokerages may reimburse their subcontractors for waiting time:

(a) In special situations, such as when the subcontractor has to wait for a client who is using the subcontractor's gurney and cannot transfer to a gurney at a medical facility; or

(b) Because of a medical issue during the ride, such as:

(A) The client is nauseous or is vomiting after dialysis or chemotherapy; or

(B) The client needs to stop to get prescription medication or medical supplies related to the medical service.

(7) Brokerages shall reimburse their subcontractors at the base rate for ambulatory vehicles if the subcontractor provides a ride to an ambulatory client in a non-ambulatory vehicle.

(8) Brokerages may authorize a subcontractor to transport a non-ambulatory client in an ambulatory vehicle if the vehicle can accommodate and transport the client and if allowed by local ordinance. The brokerage shall reimburse its subcontractor at the non-ambulatory vehicle rate.

(9) The wheelchair base rate applies to the transport of a client with a reclining wheelchair; wheelchairs do not qualify as stretchers or gurneys.

(10) The following applies to reimbursement for deceased clients:

(a) If a client dies before the subcontractor arrives at the scene, the brokerage shall not reimburse its subcontractors; or

(b) If a client dies after the transport begins but before reaching the destination, the brokerage's payment is limited to the base rate for the mode of transportation and mileage. For ambulance transports, the payment also would include costs for an extra attendant, if applicable.

(11) Brokerages may authorize shared-ride transports of two or more clients at the same time when the shared-ride transports are allowable under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Brokerages shall reimburse subcontractors:

(a) At the full base rate for the first client and one-half the base rate for each additional client when all of these clients need the same mode of transportation, such as by wheelchair van; or

(b) At the full base rate for the client with the need for the highest mode of transportation and one-half the base rate of the appropriate mode of transportation for each additional client. This applies when the additional client needs a less costly mode of transportation than the first client. For example, the first client needs an ambulance, but the additional client needs a less costly wheelchair van.

(12) When transporting two or more clients at the same time, brokerages shall pay subcontractors only from the first pickup point to the final destination under the following circumstances:

(a) The clients have a single pick up point but different destinations;

(b) The clients have different pick up points but a single destination; or

(c) The clients have different pick up points and different destinations.

(13) Brokerages shall reimburse subcontractors only for actual miles traveled, regardless of the number of clients transported.

(14) A brokerage shall not reimburse a subcontractor if:

(a) A county or city ordinance prohibits any charging for services identified in the medical transportation services administrative rules; or

(b) The subcontractor does not charge the public for such services.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3240
Client Reimbursed Mileage, Meals and Lodging

(1) The brokerage must prior authorize a client's mileage, meals and lodging to an OHP covered medical service in order for the client to qualify for reimbursement. If the brokerage prior authorized the travel costs, a client may request reimbursement up to 30 days after the travel.

(2) The client must return any documentation the brokerage requires before receiving reimbursement. Documentation required shall include a receipt for lodging.

(3) The brokerage may hold reimbursements under the amount of $10 until the client's reimbursement reaches $10.

(4) Brokerages shall reimburse clients for meals when a client, with or without an attendant, travels a minimum of four hours round-trip out of their local area. The travel, however, must span the following meal times:

(a) For a breakfast allowance, the travel must begin before 6 am;

(b) For a lunch allowance, the travel must span the entire period from 11:30 am through 1:30 pm; and

(c) For a dinner allowance, the travel must end after 6:30 pm.

(5) Brokerages shall reimburse for meals at the Authority's allowable rate.

(6) Brokerages shall not reimburse clients for meals that a hospital or other medical facility provides.

(7) Brokerages shall reimburse clients for lodging when:

(a) A client would otherwise be required to begin travel before 5 am in order to reach a scheduled appointment;

(b) Travel from a scheduled appointment would end after 9 pm; or

(c) The client's health care provider documents a medical need.

(8) Brokerages shall reimburse for lodging at the Authority's allowable rate or the actual cost of the lodging, whichever is less.

(9) Brokerages shall reimburse for meals or lodging for only one attendant, which may be a parent, to accompany the client if medically necessary, but only if:

(a) The client is a minor child and unable to travel without an attendant;

(b) The client's attending physician provides a signed statement indicating the reason an attendant must travel with the client;

(c) The client is mentally or physically unable to reach his or her medical appointment without assistance; or

(d) The client is or would be unable to return home without assistance after the treatment or service.

(10) The brokerage shall not reimburse for the attendant's time or services.

(11) If a client's health care provider admits the client for inpatient care, an attendant is no longer medically necessary because the facility provides all necessary services for the client. Therefore, the attendant is no longer eligible for lodging and travel expenses. The brokerage shall reimburse for meals and lodging for the attendant's transportation home. However, the brokerage may pay for the attendant's meals and lodging if it is more cost effective for the attendant to remain near the client to accompany the client on the return trip as allowed by section (12).

(12) Upon the client's release from inpatient care, if the attendant is medically necessary based on one of the conditions or circumstances listed in section (9), the brokerage shall reimburse for the attendant to return to the inpatient facility to accompany the client on the return trip. This only applies if the brokerage prior authorizes the attendant's travel.

(13) Brokerages shall not reimburse for mileage, meals and lodging for an attendant visiting an inpatient client, unless the physician provides a signed statement of the medical need. This exclusion includes, but is not limited to, parents of minors, breastfeeding mothers and spouses.

(14) The state shall recover overpayments made to a client. Overpayments occur when the brokerage paid the client:

(a) For mileage, meals and lodging, and another resource also paid the client;

(b) Directly to travel to medical appointments, and the client did not use the money for that purpose, did not attend the appointment or shared the ride with another client whom the brokerage also directly paid;

(c) For common carrier or public transportation tickets or passes, and the client sold or otherwise transferred the tickets or passes to another person.

(15) If a person or entity other than the client or the minor client's parent or legal guardian provides the ride, the brokerage may reimburse the person or entity that provided the ride. However, the client or the minor client's parent or legal guardian must approve in writing of the reimbursement.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3260
Modifications Based on Client Circumstances

(1) Brokerages may impose reasonable modifications on NEMT services when the client:

(a) Is threatening harm to the driver or others in the vehicle;

(b) Has a health condition that creates health or safety concerns to the driver or others in the vehicle;

(c) Has other behaviors or circumstances that place the driver or others in the vehicle at risk of harm;

(d) Frequently does not show up for scheduled rides;

(e) Frequently cancels the ride on the day of the scheduled ride time;

(f) Has behaviors that cause local medical providers or facilities to refuse to provide further services without imposing modifications; or

(g) Has special needs that require special accommodations.

(2) Reasonable modifications include, but are not limited to, requiring the client to:

(a) Use a specific transportation subcontractor;

(b) Travel with an attendant;

(c) Use public transportation where available;

(d) Drive themselves or locate someone to drive them and receive mileage reimbursement; or

(e) Confirm the ride with the brokerage on the day of or the day before the scheduled ride.

(3) Before requiring any modifications, the brokerage shall talk with the client about the reason for imposing a modification, explore modifications that are appropriate to the needs of the client and that address the health and safety concerns of the brokerages. The brokerage or client may include the client's worker, PHP or CCO in the discussion. The client may include other individuals in the discussion.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3280
Client Rights and Confidentiality

(1) Brokerages shall treat all information gathered on the client as privileged and confidential communications. The brokerage shall apply confidentiality policies to all requests for information from outside sources. Nothing prohibits the disclosure of information in summaries, statistical reports or other forms as long as the document does not identify particular individuals and cannot lead to the identification of individuals. Brokerages and any subcontractors may share information as necessary to serve the client effectively. The brokerage shall not divulge the information without the written consent of the client, the responsible parent of a minor child or the client's legal guardian. The use or disclosure of information is limited to persons directly connected to the administration of NEMT services.

(2) Brokerages or their subcontractors shall comply with OAR 407-014-0300 through 407-014-0320 pertaining to access control if the Authority grants them access to any secure computer system or information asset.

(3) The brokerage shall not deny or allow subcontractors to deny any client NEMT services based on race, color, sex, sexual orientation, religion, national origin, creed, marital status, age, health status or the presence of any sensory, mental or physical disability.

(4) Brokerages must treat clients and require subcontractors to treat clients in accordance with OAR 410-120-1855, Client Rights and Responsibilities.

(5) The brokerages shall have educational materials available for clients on its NEMT services. The Authority must first approve the materials and document the approval in writing.

(6) As required by 42 CFR 431, a brokerage shall follow OAR 410-120-1860 and 410-120-1865 pertaining to contested case hearings when it denies a ride, with the following exceptions:

(a) The brokerage must immediately provide a secondary review by another employee when the initial screener denies a ride; and

(b) The brokerage must mail a notice of action to a client denied a ride within 72 hours of denying a ride.

(7) Upon the Authority's request, brokerages shall provide documentation pertaining to discovery for or investigation of contested case hearings pursuant to OAR 410-120-1360.

(8) Brokerages shall provide documentation pertaining to discovery for or investigation of contested case hearings when the client, the responsible parent of a minor child or the client's legal guardian requests the documentation. The brokerage shall provide the documentation to the client's legal representative upon written consent from the client, the responsible parent of a minor child or the client's legal guardian.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3300
Reports and Documentation

(1) Brokerages shall maintain documentation of rides denied and rides provided to clients. This documentation shall include, but is not limited, to:

(a) The name of the client and the person requesting the ride on behalf of the client, if applicable;

(b) The client's OHP medical care identification number;

(c) The date and time of the request for transportation;

(d) The mode of transport authorized for the client and a justification for authorizing a mode of transport that is not reasonably understandable;

(e) The location for picking-up the client and the destination;

(f) The medical reason for the appointment;

(g) The availability of other transportation resources and the justification for authorizing a ride when the client has other resources;

(h) The subcontractor assigned to give the ride and the date and time the brokerage notified the subcontractor of the assignment;

(i) The name of the employee who approved a ride; and

(j) In the case of a denial of a ride:

(A) The name of the employee who denied a ride;

(B) The name of the employee who performed the secondary review before denying the ride;

(C) The reason for the denial and the applicable Oregon administrative rule that supports the denial;

(D) The date on the notice of action the brokerage mailed to the client;

(E) Documentation on the brokerage's review, resolution, or disposition of the matter, if applicable, including the reason for the decision and the date of the resolution or disposition; and

(F) Notations of oral and written communications with the client.

(2) The brokerage shall retain the documentation on denials of rides for three calendar years, even if the brokerage is no longer a Medicaid enrolled provider before the end of the three years. The Authority may request this information at any time during the three year retention period.

(3) The brokerage shall maintain billing files organized by subcontractor that justify the number of transports and with cross references to actual rides and specific clients.

(4) The brokerages shall report monthly on estimated revenue and expenses that affect the balance of the working capital reserve amount. The report must contain the following costs as they pertain to providing NEMT services:

(a) Sub-totals of administrative expenses, including:

(A) Salaries and wages of the brokerage's employees;

(B) Payroll related expenses for the brokerage's employees;

(C) Other employee related expenses, such as recruitment and advertising;

(D) Computer hardware and software purchased, leased or licensed;

(E) Office supplies such as stamps, paper or printing;

(F) Non-computer related equipment purchased, leased or licensed;

(G) Telephone;

(H) Administrative support and other indirect charges;

(I) Education and training;

(J) Building expenses such as leases, rents, security, janitorial services and repairs that retain the property's operating condition but do not add to the permanent value of the property;

(K) Subcontractor identification and drug testing, such as fingerprinting and drug analysis;

(L) Legal expense not related to the Authority, such as attorney fees; fines or penalties;

(M) Indirect expenses, such as accounting, human resources, risk management or insurance;

(N) Sub-contracts for operations or temporary employees;

(O) Required driver training, if applicable;

(P) The client satisfaction survey, if applicable;

(Q) Software maintenance, if applicable; and

(R) Details of other administrative expenses not specified above.

(b) The number and costs of the following:

(A) Stretcher car rides;

(B) Wheelchair rides;

(C) Ambulatory rides;

(D) Secured transports;

(E) Bus tickets;

(F) Bus passes;

(G) NEMT ambulance transports;

(H) Reimbursements to clients; and

(I) Commercial transports.

(c) The amount of credits to subcontractors.

(d) Information on the brokerage's working capital reserve, including:

(A) The Authority-calculated working capital reserve;

(B) The estimated working capital reserve as of the beginning of the fiscal year;

(C) The estimated working capital reserve as of this report; and

(D) The difference between sub-sections (B) and (C).

(5) The financial reports must show the number of rides that volunteer drivers provide.

(6) Brokerages must submit the financial report required in Section (4) of this rule within 45 days of the end of the reporting month.

(7) Brokerages shall submit a cost allocation plan that includes anticipated expenses, certified by the brokerage's Chief Financial Officer, to the Authority no later than April 1 of each year for the upcoming fiscal year.

(8) The Authority may request, and the brokerage shall provide, other reports or information not specified in sections (1), (3), (4) and (6) of this rule.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3320
Audits

(1) The Authority, the Oregon Secretary of State Audits Division, the Oregon Department of Justice and the federal government may audit the brokerage's or its subcontractor's records at least annually. The audit shall include, but is not limited to, the following areas:

(a) Financial status;

(b) Performance and quality of the service;

(c) Efficiency and effectiveness of the program's operation; and

(d) The relationship between the funds provided by the Authority and the amounts expended by brokerages or billed by subcontractors and that the use of funds is reasonable and necessary to provide quality service.

(2) The Authority, the Oregon Secretary of State Audits Division, the Oregon Department of Justice, and the federal government may review the brokerage's or subcontractor's records whenever necessary to verify delivery of service, financial and operational status, and compliance with Oregon administrative rules or to investigate unresolved questions of fact.

(3) As specified by 42 CFR 455.17, brokerages and subcontractors shall report to the Authority any suspected fraud or abuse of NEMT services. If the suspected fraud or abuse is subcontractor-related, and the brokerage or the Authority determines the subcontractor has committed fraud, the brokerage shall immediately terminate its subcontract.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.065
Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3340
Brokerage Service Areas

(1) Brokerages enrolled with the Authority shall arrange and pay for NEMT services to all eligible clients in the counties shown in Table 136-3340.

(2) OHP clients shall use only the brokerages available in their county of residence unless they have permission from their local brokerage to use another brokerage.

(3) Nothing in this rule precludes brokerages from coordinating to provide rides to clients in another brokerage if it would be more cost effective or provide better service for the client.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

410-136-3360

Discontinuation of Brokerage as Enrolled Provider

(1) A brokerage may discontinue being an enrolled provider for NEMT services only with notice to the Authority. The following establishes the requirements for notice:

(a) If the reason is for the brokerage's convenience: The effective date must be at least 90 days after the brokerage sends written notice; and (ii) the effective date must be on the first calendar date of the month ;

(b) The brokerage must provide 45 days advance written notice if the brokerage does not obtain funding, appropriations and other expenditure authorizations from its governing body, federal, state or other sources sufficient to permit the brokerage to satisfy its requirements pursuant to these rules (OAR 410-136-3000 through 410-130-3360);

(c) Immediately upon written notice if the Oregon Legislative Assembly, the federal government or a court interprets, modifies or changes Oregon statutes or federal laws, regulations or guidelines in such a way that the brokerage immediately has no authority to satisfy the requirements of these rules.

(2) The Authority may discontinue allowing a brokerage to provide NEMT services as an enrolled provider only with notice to the brokerage. The following establishes the requirements for notice:

(a) If the reason is for the Authority's convenience:

(A) The effective date must be at least 90 days after the Authority sends written notice; and

(B) the effective date must be on the first calendar date of a month.

(b) The Authority must provide 45 days advance written notice if the Authority does not obtain funding, appropriations and other expenditure authorizations from its governing body, federal, state or other sources sufficient to meet its payment obligations pursuant to OAR 410-136-3200, Reimbursement and Accounting for all Modes of Transportation.

(c) Immediately upon written notice if the Oregon Legislative Assembly, the federal government or a court interprets, modifies or changes Oregon statutes or federal laws, regulations or guidelines in such a way that the Authority immediately has no authority to provide NEMT services pursuant to these rules.

(d) Immediately upon written notice to the brokerage if the Oregon Legislative Assembly or Emergency Board reduces the Authority's expenditure authorization, resulting in the following:

(A) The Authority cannot meet its payment obligations pursuant to OAR 410-136-3200, Reimbursement and Accounting for all Modes of Transportation; and

(B) The effective date for the reduction in expenditure authorization is less than 45 days from the date the Legislative Assembly or Emergency Board takes the action.

(e) Immediately upon written notice to the brokerage if a law or regulation requires a brokerage to have any license or certificate, and the license or certificate is denied, revoked, suspended, not renewed or changed in such a way that brokerage no longer meets requirements to deliver NEMT services. The Authority may only exercise this right with respect to the particular service impacted by the loss of the licensure or certification.

(f) Immediately upon written notice to the brokerage, if the Authority determines the brokerage any of its subcontractors have endangered or are endangering the health or safety of a client or others.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

Hist: DMAP 36-2013, f. 6-27-13, cert. ef. 7-1-13

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Rule Caption: Change chemical dependency to substance use disorder , detox services available in other settings.

Adm. Order No.: DMAP 37-2013(Temp)

Filed with Sec. of State: 6-27-2013

Certified to be Effective: 7-1-13 thru 12-24-13

Notice Publication Date:

Rules Amended: 410-120-0000, 410-120-1160, 410-120-1200, 410-120-1210, 410-120-1855

Subject: The Division of Medical Assistance Programs (Division) General Rules, administrative rules govern payments for services provided to certain eligible clients. The Division temporarily amends OAR 410-120-0000, 410-120-1160, 410-120-1200, 410-120-1210, 410-120-1855 to reflect that detox services are available in other settings than Hospitals and to replace "chemical Dependency" with "Substance Use Disorder" as it is considered to be the standard terminology.

Rules Coordinator: Cheryl Peters—(503) 945-6527

410-120-0000

Acronyms and Definitions

Identification of acronyms and definitions within this rule specifically pertain to their use within the Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division) or the Addictions and Mental health Division (AMH) administrative rules applicable to the medical assistance program. This rule does not include an exhaustive list of Division acronyms and definitions. For more information, see Oregon Health Plan (OHP) program OAR 410-141-0000, Acronyms and Definitions, 410-141-0300, and any appropriate governing acronyms and definitions in the Department of Human Services (Department) chapter 407 administrative rules, or contact the Division.

(1) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Authority, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Authority.

(2) "Acupuncturist" means a person licensed to practice acupuncture by the relevant state licensing board.

(3) "Acupuncture Services" means services provided by a licensed acupuncturist within the scope of practice as defined under state law.

(4) "Acute" means a condition, diagnosis or illness with a sudden onset and that is of short duration.

(5) "Acquisition Cost" means unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply or equipment, plus any shipping and/or postage for the item.

(6) "Addiction and Mental Health Division (AMH)" means a division within the Authority that administers mental health and addiction programs and services.

(7) "Adequate Record Keeping" means documentation that supports the level of service billed. See 410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual provider rules.

(8) "Administrative Medical Examinations and Reports" mean examinations, evaluations, and reports, including copies of medical records, requested on the DMAP 729 form through the local Department branch office or requested or approved by the Authority to establish client eligibility for a medical assistance program or for casework planning.

(9) "Advance Directive" means an individual's instructions to an appointed individual specifying actions to take in the event that the individual is no longer able to make decisions due to illness or incapacity.

(10) "Adverse Event" means an undesirable and unintentional, though not unnecessarily unexpected, result of medical treatment.

(11) "Aging and People with Disabilities (APD)" means the division in the Department of Human Services (DHS) that administers programs for seniors and people with disabilities. This division was formerly named "Seniors and People with Disabilities (SPD)".

(12) "All-Inclusive Rate" or "Bundled rate" means the nursing facility rate established for a facility. This rate includes all services, supplies, drugs and equipment as described in OAR 411-070-0085, and in the Division's Pharmaceutical Services program administrative rules and the Home Enteral/Parenteral Nutrition and IV Services program administrative rules, except as specified in OAR 410-120-1340, Payment.

(13) "Allied Agency" means local and regional governmental agency and regional authority that contracts with the Authority or Department to provide the delivery of services to covered individual. (e.g., local mental health authority, community mental health program, Oregon Youth Authority, Department of Corrections, local health departments, schools, education service districts, developmental disability service programs, area agencies on aging (AAAs), federally recognized American Indian tribes).

(14) "Alternative Care Settings" mean sites or groups of practitioners that provide care to members under contract with a PHP or CCO, including

urgent care centers, hospice, birthing centers, out-placed medical teams in community or mobile health care facilities, long-term care facilities and outpatient surgical centers.

(15) "Ambulance" means a specially equipped and licensed vehicle for transporting sick or injured persons which meets the licensing standards of the Authority or the licensing standards of the state in which the ambulance provider is located.

(16) "Ambulatory Payment Classification" means a reimbursement method that categorizes outpatient visits into groups according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed. The groups are called Ambulatory Payment Classifications (APCs).

(17) "Ambulatory Surgical Center (ASC)" means a facility licensed as an ASC by the Authority.

(18) "American Indian/Alaska Native (AI/AN)" means a member of a federally recognized Indian tribe, band or group, an Eskimo or Aleut or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601, or a person who is considered by the Secretary of the Interior to be an Indian for any purpose.

(19) "American Indian/Alaska Native (AI/AN) Clinic" means a clinic recognized under Indian Health Services (IHS) law or by the Memorandum of Agreement between IHS and the Centers for Medicare and Medicaid Services (CMS).

(20) "Ancillary Services" mean services supportive of or necessary for providing a primary service, such as, anesthesiology, which is an ancillary service necessary for a surgical procedure.

(21) "Anesthesia Services" mean administration of anesthetic agents to cause loss of sensation to the body or body part.

(22) "Area Agency on Aging (AAA)" means the designated entity with which the Department contracts to meet the requirements of the Older Americans Act and ORS Chapter 410 in planning and providing services to the elderly or elderly and disabled population.

(23) "Atypical Provider" means entity able to enroll as a billing provider (BP) or rendering provider for medical assistance programs related non-health care services but which does not meet the definition of health care provider for National Provider Identification (NPI) purposes.

(24) "Audiologist" means a person licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.

(25) "Audiology" means the application of principles, methods and procedures of measurement, testing, appraisal, prediction, consultation, counseling and instruction related to hearing and hearing impairment for the purpose of modifying communicative disorders involving speech, language, auditory function, including auditory training, speech reading and hearing aid evaluation, or other behavior related to hearing impairment.

(26) "Automated Voice Response (AVR)" means a computer system that provides information on clients' current eligibility status from the Division by computerized phone or Web-based response.

(27) "Benefit Package" means the package of covered health care services for which the client is eligible.

(28) "Billing Agent or Billing Service" means third party or organization that contracts with a provider to perform designated services in order to facilitate an Electronic Data Interchange (EDI) transaction on behalf of the provider.

(29) "Billing Provider (BP)" means a person, agent, business, corporation, clinic, group, institution, or other entity who submits claims to and/or receives payment from the Division on behalf of a rendering provider and has been delegated the authority to obligate or act on behalf of the rendering provider.

(30) "Buying Up" means the practice of obtaining client payment in addition to the Division or managed care plan payment to obtain a non-covered service or item. (See 410-120-1350 Buying Up).

(31) "By Report (BR): means services designated, as BR require operative or clinical and other pertinent information to be submitted with the billing as a basis for payment determination. This information must include an adequate description of the nature, and extent of need for the procedure. Information such as complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care will facilitate evaluation.

(32) "Case Management Services" mean services provided to ensure that CCO members obtain health services necessary to maintain physical, mental and emotional development and oral health. Case management services include a comprehensive, ongoing assessment of medical, mental health, substance use disorder and/or dental needs plus the development and implementation of a plan to obtain or make referrals for needed medical, mental, chemical dependency or dental services, referring members to community services and supports which may include referrals to Allied Agencies.

(33) "Children, Adults and Families Division (CAF)" means a division within the Department, responsible for administering self-sufficiency and child-protective programs.

(34) "Children's Health Insurance Program (CHIP)" means a federal and state funded portion of the Oregon Health Plan (OHP) established by Title XXI of the Social Security Act and administered by the Authority.

(35) "Chiropractor" means a person licensed to practice chiropractic by the relevant state licensing board.

(36) "Chiropractic Services" mean services provided by a licensed chiropractor within the scope of practice, as defined under state law and Federal regulation.

(37) "Citizen/Alien-Waived Emergency Medical (CAWEM)" means aliens granted lawful temporary resident status, or lawful permanent resident status under the Immigration and Nationality Act, are eligible only for emergency services and limited service for pregnant women. Emergency services for CAWEM are defined in OAR 410-120-1210(3)(f).

(38) "Claimant" means a person who has requested a hearing.

(39) "Client" means an individual found eligible to receive OHP health services. "Client" is inclusive of members enrolled in PHPs, PCMs and CCOs.

(40) "Clinical Nurse Specialist" means a registered nurse who has been approved and certified by the Board of Nursing to provide health care in an expanded specialty role.

(41) "Clinical Social Worker" means a person licensed to practice clinical social work pursuant to State law.

(42) "Clinical Record" means the medical, dental or mental health records of a client or member.

(43) "Comfort Care" means medical services or items that give comfort or pain relief to an individual who has a terminal Illness, including the combination of medical and related services designed to make it possible for an individual with terminal Illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness.

(44) "Contested Case Hearing" means a proceeding before the Authority under the Administrative Procedures Act when any of the following contests an action:

(a) A client or member or their representative;

(b) A PHP or CCO member's provider; or

(c) A PHP or CCO.

(45) "Contiguous Area" means the area up to 75 miles outside the border of the State of Oregon.

(46) "Contiguous Area Provider" means a provider practicing in a contiguous area.

(47) "Continuing Treatment Benefit" means a benefit for clients who meet criteria for having services covered that were either in a course of treatment or scheduled for treatment the day immediately before the date the client's benefit package changed to one that does not cover the treatment.

(48) "Co-Payments" mean the portion of a claim or medical, dental or pharmaceutical expense that a client must pay out of their own pocket to a provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered. (See 410-120-1230 Client Copayment).

(49) "Cost Effective" means the lowest cost health service or item that, in the judgment of Authority staff or its contracted agencies, meets the medical needs of the client.

(50) "Cover Oregon" means the state's health insurance exchange that will help individuals find out if they qualify for Medicaid, CHIP or health insurance coverage for themselves, their families and their employees.

(51) "Covered Services" means medically appropriate health services described in ORS Chapter 414 and applicable administrative rules that the Legislature funds, based on the Prioritized List of Health Services.

(52) "Current Dental Terminology (CDT)" means a listing of descriptive terms identifying dental procedure codes used by the American Dental Association.

(53) "Current Procedural Terminology (CPT)" means the physicians' CPT is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other health care providers.

(54) "Date of Receipt of a Claim" means the date on which the Authority receives a claim, as indicated by the Internal Control Number (ICN) assigned to a claim. Date of receipt is shown as the Julian date in the 5th through 7th position of the ICN.

(55) "Date of Service" means the date on which the client receives medical services or items, unless otherwise specified in the appropriate

provider rules. For items that are mailed or shipped by the provider, the date of service is the date on which the order was received, the date on which the item was fabricated, or the date on which the item was mailed or shipped.

(56) "Dental Emergency Services" mean dental services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.

(57) "Dental Services" mean services provided within the scope of practice as defined under state law by or under the supervision of a dentist or dental hygienist.

(58) "Dentist" means a person licensed to practice dentistry pursuant to state law of the state in which he/she practices dentistry, or a person licensed to practice dentistry pursuant to Federal law for the purpose of practicing dentistry as an employee of the Federal government.

(59) "Denturist" means a person licensed to practice denture technology pursuant to State law.

(60) "Denturist Services" mean services provided, within the scope of practice as defined under State law, by or under the personal supervision of a denturist.

(61) "Dental Hygienist" means a person licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to State law.

(62) "Dental Hygienist with an Expanded Practice Permit" means a person licensed to practice dental hygiene services as authorized by the Board of Dentistry with an Expanded Practice Dental Hygienist Permit (EPDHP) pursuant to State law.

(63) "Dentally Appropriate" means services that are required for prevention, diagnosis or treatment of a dental condition and that are:

(a) Consistent with the symptoms of a dental condition or treatment of a dental condition;

(b) Appropriate with regard to standards of good dental practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of the client or a provider of the service;

(d) The most cost effective of the alternative levels of dental services that can be safely provided to a client.

(64) "Department of Human Services (Department or DHS)" means the agency established in ORS Chapter 409, including such divisions, programs and offices as may be established therein.

(65) "Department Representative" means a person who represents the Department and presents the position of the Department in a hearing.

(66) "Diagnosis Code" means as identified in the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM), the primary diagnosis code is shown in all billing claims, unless specifically excluded in individual provider rule(s). Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.

(67) "Diagnosis Related Group (DRG)" means a system of classification of diagnoses and procedures based on the ICD-9-CM.

(68) "Division of Medical Assistance Programs (Division)" means a division within the Authority; the Division is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP -Title XXI), and several other programs.

(69) "Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)" mean equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose. Examples include wheelchairs, respirators, crutches and custom built orthopedic braces. Medical supplies are non-reusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages and tubing.

(70) "Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (aka, Medicheck)" mean the Title XIX program of EPSDT services for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically appropriate health care services and to help Authority clients and their parents or guardians effectively use them.

(71) "Electronic Data Interchange (EDI)" means the exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, using bulk transmission processes and other formats as the Authority designates for EDI transactions. For purposes of rules 407-120-0100 through 407-120-0200, EDI does not include electronic transmission by web portal.

(72) "EDI Submitter" means an individual or an entity authorized to establish an electronic media connection with the Authority to conduct an EDI transaction. An EDI submitter may be a trading partner or an agent of a trading partner.

(73) "Electronic Verification System (EVS)" means eligibility information that has met the legal and technical specifications of the Authority in order to offer eligibility information to enrolled providers of the Division.

(74) "Emergency Department" means the part of a licensed hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.

(75) "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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 health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An emergency medical condition is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence. (This definition does not apply to clients with CAWEM benefit package. CAWEM emergency services are governed by OAR 410-120-1210(3)(f)(B)).

(76) "Emergency Medical Transportation" means transportation necessary for a client with an emergency medical condition, as defined in this rule, and requires a skilled medical professional such as an Emergency Medical Technician (EMT) and immediate transport to a site, usually a hospital, where appropriate emergency medical service is available.

(77) "Emergency Services" means health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient's condition is not likely to materially deteriorate from or during a client's discharge from a facility or transfer to another facility.

(78) "Evidence-Based Medicine" means the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer. (Source: BMJ 1996; 312:71-72 (13 January)).

(79) "False Claim" means a claim that a provider knowingly submits or causes to be submitted that contains inaccurate, misleading or omitted information and such inaccurate, misleading or omitted information would result, or has resulted, in an overpayment.

(80) "Family Health Insurance Assistance Program (FHIAP)" means a program in which the State subsidizes premiums in the commercial insurance market for uninsured individuals and families with income below 185% of the Federal Poverty Level.

(81) "Family Planning Services" mean services for clients of child bearing age (including minors who can be considered to be sexually active) who desire such services and which are intended to prevent pregnancy or otherwise limit family size.

(82) "Federally Qualified Health Center (FQHC)" means a federal designation for a medical entity which receives grants under Section 329, 330, or 340 of the Public Health Service Act; or a facility designated as an FQHC by Centers for Medicare and Medicaid (CMS) upon recommendation of the U.S. Public Health Service.

(83) "Fee-for-Service Provider" means a health care provider who is not reimbursed under the terms of a Authority contract with a Coordinated Care Organization or Prepaid Health Plan (PHP) . A medical provider par-

ticipating in a PHP or a CCO may be considered a fee-for-service provider when treating clients who are not enrolled in a PHP or a CCO.

(84) "Flexible Service" means a service that is an alternative or addition to a service that is as likely or more likely to effectively treat the mental condition, substance use disorder condition, or physical condition as documented in the Member's Clinical Record. Flexible Services may include, but are not limited to: Respite Care, Partial Hospitalization, Subacute Psychiatric Care, Family Support Services, Parent Psychosocial Skills Development, Peer Services, and other non-Traditional Services identified.

(85) "Flexible Service Approach" means the delivery of any Coordinated Care Service in a manner or place different from the traditional manner or place of service delivery. A Flexible Service Approach may include delivering Coordinated Care Services at alternative sites such as schools, residential facilities, nursing facilities, Members' homes, emergency rooms, offices of DHS, OHA, other community settings; offering flexible clinic hours; offering Coordinated Care Services through outreach or a home-based approach; and using peers, paraprofessionals, Community Health Workers, Peer Wellness Specialists, or Personal Health Navigators who are Culturally Competent to engage difficult-to-reach Members.

(86) "Fraud" means 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. It includes any act that constitutes fraud under applicable federal or state law.

(87) "Fully Dual Eligible" means for the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by the Department for full medical assistance coverage.

(88) "General Assistance (GA)" means medical assistance administered and funded 100% with State of Oregon funds through OHP.

(89) "Healthcare Common Procedure Coding System (HCPCS)" means a method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level 1 — American Medical Association's Physician's Current Procedural Terminology (CPT), Level II — National codes, and Level III — Local codes. The Division uses HCPCS codes; however, Division uses Current Dental Terminology (CDT) codes for the reporting of dental care services and procedures.

(90) "Health Care Professionals" mean individuals with current and appropriate licensure, certification or accreditation in a medical, mental health or dental profession who provide health services, assessments and screenings for clients within their scope of practice, licensure or certification.

(91) "Health Evidence Review Commission" means a commission that, among other duties, develops and maintains a list of health services ranked by priority, from the most to the least important, representing the comparative benefits of each service to the population served.

(92) "Health Insurance Portability and Accountability Act (HIPAA) of 1996 (HIPAA)" means the federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information and guarantee security and privacy of health information.

(93) "Health Maintenance Organization (HMO)" means a public or private health care organization which is a federally qualified HMO under Section 1310 of the U.S. Public Health Services Act. HMOs provide health care services on a capitated, contractual basis.

(94) "Health Plan New/noncategorical client (HPN)" means an individual who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program and who must meet all eligibility requirements to become an OHP client.

(95) "Hearing Aid Dealer" means a person licensed by the Board of Hearing Aid Dealers to sell, lease or rent hearing aids in conjunction with the evaluation or measurement of human hearing and the recommendation, selection, or adaptation of hearing aids.

(96) "Home Enteral Nutrition" means services provided in the client's place of residence to an individual who requires nutrition supplied by tube into the gastrointestinal tract, as described in the Home Enteral/Parenteral Nutrition and IV Services program provider rules.

(97) "Home Health Agency" means a public or private agency or organization which has been certified by Medicare as a Medicare home health agency and which is licensed by the Authority as a home health agency in Oregon, and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997.

(98) "Home Health Services" mean part-time or intermittent skilled nursing services, other therapeutic services (physical therapy, occupational therapy, speech therapy), and home health aide services made available on a visiting basis in a place of residence used as the client's home.

(99) "Home Intravenous Services" mean services provided in the client's place of residence to an individual who requires that medication (antibiotics, analgesics, chemotherapy, hydrational fluids, or other intravenous medications) be administered intravenously as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.

(100) "Home Parenteral Nutrition" means services provided in the client's residence to an individual who is unable to absorb nutrients via the gastrointestinal tract, or for other medical reasons, requires nutrition be supplied parenterally as described in the Home Enteral/Parenteral Nutrition and IV Services program administrative rules.

(101) "Hospice" means a public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals, and is certified by the federal Centers for Medicare and Medicaid Services as a program of hospice services meeting current standards for Medicare and Medicaid reimbursement and Medicare Conditions of Participation; and currently licensed by the Oregon Health Authority (Authority), Public Health Division.

(102) "Hospital" means a facility licensed by the Office of Public Health Systems as a general hospital which meets requirements for participation in OHP under Title XVIII of the Social Security Act. The Division does not consider facilities certified by CMS as long-term care hospitals, long-term acute care hospitals or religious non-medical facilities as hospitals for reimbursement purposes. Out-of-state hospitals will be considered hospitals for reimbursement purposes if they are licensed as a short term acute care or general hospital by the appropriate licensing authority within that state, and if they are enrolled as a provider of hospital services with the Medicaid agency within that state.

(103) "Hospital-Based Professional Services" mean professional services provided by licensed practitioners or staff based on a contractual or employee/employer relationship and reported as a cost on the Hospital Statement of Reasonable Cost report for Medicare and the Calculation of Reasonable Cost (Division 42) report for the Division.

(104) "Hospital Dentistry" means dental services normally done in a dental office setting, but due to specific client need (as detailed in OAR chapter 410 division 123) are provided in an ambulatory surgical center, inpatient, or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).

(105) "Hospital Laboratory" means a laboratory providing professional technical laboratory services as outlined under laboratory services, in a hospital setting, as either an inpatient or outpatient hospital service whose costs are reported on the hospital's cost report to Medicare and to the Division.

(106) "Indian Health Care Provider" means an Indian health program or an urban Indian organization.

(107) "Indian Health Program" means any Indian Health Service (IHS) facility, any Federally recognized Tribe or Tribal organization, or any FQHC with a 638 designation.

(108) "Indian Health Service (IHS)" means an operating division (OPDIV) within the U.S. Department of Health and Human Services (HHS) responsible for providing medical and public health services to members of federally recognized Tribes and Alaska Natives.

(109) "Indigent" means for the purposes of access to the Intoxicated Driver Program Fund (ORS 813.602) indigent has the meaning: Individuals with out health insurance coverage, public or private and meet standards for indigence adopted by the federal government as defined in ORS 813.602 (5).

(110) "Individual Adjustment Request Form (DMAP 1036)" means form used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.

(111) "Inpatient Hospital Services" mean services that are furnished in a hospital for the care and treatment of an inpatient. (See Division Hospital Services program administrative rules in chapter 410, division 125 for inpatient covered services.)

(112) "Institutional Level of Income Standards (ILIS)" mean three times the amount SSI pays monthly to a person who has no other income and who is living alone in the community. This is the standard used for Medicaid eligible individuals to calculate eligibility for long-term nursing care in a nursing facility, Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and individuals on ICF/MR waivers or eligibility for services under Seniors and People with Disabilities' (SPD) Home and Community Based Waiver.

(113) "Institutionalized" means a patient admitted to a nursing facility or hospital for the purpose of receiving nursing and/or hospital care for a period of 30 days or more.

(114) "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) (including volumes 1, 2, and 3, as revised annually)" mean a book of diagnosis codes used for billing purposes when treating and requesting reimbursement for treatment of diseases.

(115) "Laboratory" means a facility licensed under ORS 438 and certified by CMS, Department of Health and Human Services (DHHS), as qualified to participate under Medicare, to provide laboratory services (as defined in this rule) within or apart from a hospital. An entity is considered to be a laboratory if the entity derives materials from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings. If an entity performs even one laboratory test, including waived tests for these purposes, it is considered to be a laboratory, under the Clinical Laboratory Improvement Act (CLIA).

(116) "Laboratory Services" mean those professional and technical diagnostic analyses of blood, urine, and tissue ordered by a physician or other licensed practitioner of the healing arts within his/her scope of practice as defined under State law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent laboratory.

(117) "Licensed Direct Entry Midwife" means a practitioner who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery by the Public Health Division.

(118) "Liability Insurance" means insurance that provides payment based on legal liability for injuries or illness. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowner's liability insurance, malpractice insurance, product liability insurance, Worker's Compensation, and general casualty insurance. It also includes payments under state wrongful death statutes that provide payment for medical damages.

(119) "Managed Care Organization (MCO)" means contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging and making reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a Chemical Dependency Organization (CDO), Fully Capitated Health Plan (FCHP), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).

(120) "Maternity Case Management" means a program available to pregnant clients. The purpose of Maternity Case Management is to extend prenatal services to include non-medical services, which address social, economic and nutritional factors. For more information refer to the Division's Medical-Surgical Services Program administrative rules.

(121) "Medicaid" means a federal and state funded portion of the medical assistance programs established by Title XIX of the Social Security Act, as amended, administered in Oregon by the Authority.

(122) "Medical Assistance Eligibility Confirmation" means verification through the Electronic Verification System (EVS), AVR, Secure Web site or Electronic Data Interchange (EDI), or an authorized Department or Authority representative.

(123) "Medical Assistance Program" means a program for payment of health services provided to eligible Oregonians, including Medicaid and CHIP services under the OHP Medicaid Demonstration Project, and Medicaid and CHIP services under the State Plan.

(124) "Medical Care Identification" means the card commonly called the "medical card" or medical ID issued to clients. (called the Oregon Health ID starting Aug. 1, 2012).

(125) "Medical Services" mean care and treatment provided by a licensed medical provider directed at preventing, diagnosing, treating or correcting a medical problem.

(126) "Medical Transportation" means transportation to or from covered medical services.

(127) "Medically Appropriate" means services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community, evidence-based medicine and professional standards of care as effective;

(c) Not solely for the convenience of an OHP client or a provider of the service or medical supplies; and

(d) The most cost effective of the alternative levels of medical services or medical supplies which can be safely provided to a Division client or Primary Care Manager (PCM) Member in the PHP's or PCM's judgment.

(128) "Medicare" means a federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons. This program includes:

(a) Hospital Insurance (Part A) for Inpatient services in a hospital or skilled nursing facility, home health care, and hospice care; and

(b) Medical Insurance (Part B) for physicians' services, outpatient hospital services, home health care, end-stage renal dialysis, and other medical services and supplies;

(c) Prescription drug coverage (Part D) means covered Part D drugs include prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Social Security Act, and vaccines licensed under section 351 of the Public Health Service Act; also includes medical supplies associated with the injection of insulin; Part D covered drugs prohibit Medicaid Title XIX Federal Financial Participation (FFP). For limitations, see the Division's Pharmaceutical Services program administrative rules in chapter 410, division 121.

(129) "Medicare Advantage" means an organization approved by CMS to offer Medicare health benefits plans to Medicare beneficiaries.

(130) "Medicheck for Children and Teens" mean services also known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. The Title XIX program of EPSDT services for eligible clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically appropriate health care services and to help Authority clients and their parents or guardians effectively use them.

(131) "Member" means an OHP client enrolled with a pre-paid health plan or coordinated care organization.

(132) "Mental Health Case Management" means services provided to CCO members who require assistance to ensure access to mental health benefits and services from local, regional or state allied agencies or other service providers. Services provided may include: advocating for the CCO member's treatment needs; providing assistance in obtaining entitlements based on mental or emotional disability; referring CCO members to needed services or supports; accessing housing or residential programs; coordinating services, including educational or vocational activities; and establishing alternatives to inpatient psychiatric services.

(133) " National Correct Coding Initiative (NCCI)" means the Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment.

(134) "National Drug Code or (NDC)" means a universal number that identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The Food and Drug Administration assigns the first five digits to identify the manufacturer of the drug. The manufacturer assigns the remaining digits to identify the specific product and package size. Some packages will display less than 11 digits, but the number assumes leading zeroes.

(135) "National Provider Identification (NPI)" means federally directed provider number mandated for use on HIPAA covered transactions; individuals, provider organizations and subparts of provider organizations that meet the definition of health care provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI; Medicare covered entities are required to apply for an NPI.

(136) "Naturopathic physician" means a person licensed to practice naturopathic medicine by the Oregon Board of Naturopathic Medicine.

(137) "Naturopathic Services" means services provided within the scope of practice as defined under State law and by rules of the Oregon Board of Naturopathic Medicine.

(138) "Non-covered Services" mean services or items for which the Authority is not responsible for payment or reimbursement. Non-covered services are identified in:

(a) OAR 410-120-1200, Excluded Services and Limitations; and

(b) 410-120-1210, Medical Assistance Benefit Packages and Delivery System;

(c) 410-141-0480, OHP Benefit Package of Covered Services;

(d) 410-141-0520, Prioritized List of Health Services; and

(e) Any other applicable Division administrative rules.

(139) "Non-Emergent Medical Transportation Services (NEMT) "means transportation to or from a source of covered service, which does

not involve a sudden, unexpected occurrence that creates a medical crisis requiring emergency medical services, as defined in OAR 410-120-0000(49), and requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available.

(140) "Non-Paid Provider" means a provider who is issued a provider number for purposes of data collection or non-claims-use of the Provider Web Portal (e.g., eligibility verification).

(141) "Nurse Anesthetist, C.R.N.A." means a registered nurse licensed in the State of Oregon as a CRNA who is currently certified by the National Board of Certification and Recertification for Nurse Anesthetists.

(142) "Nurse Practitioner" means a person licensed as a registered nurse and certified by the Board of Nursing to practice as a Nurse Practitioner pursuant to State law.

(143) "Nurse Practitioner Services" mean services provided within the scope of practice of a Nurse Practitioner as defined under State law and by rules of the Board of Nursing.

(144) "Nursing Facility" means a facility licensed and certified by the Department SPD and defined in OAR 411-070-0005.

(145) "Nursing Services" mean health care services provided to a patient by a registered professional nurse or a licensed practical nurse under the direction of a licensed professional within the scope of practice as defined by State law.

(146) "Nutritional Counseling" means counseling which takes place as part of the treatment of a person with a specific condition, deficiency or disease such as diabetes, hypercholesterolemia, or phenylketonuria.

(147) "Occupational Therapist" means a person licensed by the State Board of Examiners for Occupational Therapy.

(148) "Occupational Therapy" means the functional evaluation and treatment of individuals whose ability to adapt or cope with the task of living is threatened or impaired by developmental deficiencies, physical injury or illness, aging process, or psychological disability; the treatment utilizes task-oriented activities to prevent or correct physical and emotional difficulties or minimize the disabling effect of these deficiencies on the life of the individual.

(149) "Ombudsman Services" mean advocacy services provided by the Authority to clients whenever the client is reasonably concerned about access to, quality of or limitations on the health services provided.

(150) "Oregon Health ID" means a card the size of a business card that lists the client name, client ID (prime number) and the date it was issued.

(151) "Oregon Health Plan (OHP)" means the Medicaid and Children's Health Insurance (CHIP) Demonstration Project which expands Medicaid and CHIP eligibility beyond populations traditionally eligible for Medicaid to other low-income populations, and Medicaid and CHIP services under the State Plan

(152) "Optometric Services" mean services provided, within the scope of practice of optometrists as defined under State law.

(153) "Optometrist" means a person licensed to practice optometry pursuant to State law.

(154) "Oregon Health Authority (Authority or OHA)" means the agency established in ORS Chapter 413 that administers the funds for Titles XIX and XXI of the Social Security Act. It is the single state agency for the administration of the medical assistance program under ORS chapter 414. For purposes of these rules, the agencies under the authority of the OHA are the Public Health Division, the Addictions and Mental Health Division, and the Division of Medical Assistance Programs.

(155) "Oregon Youth Authority (OYA)" means the state department charged with the management and administration of youth correction facilities, state parole and probation services and other functions related to state programs for youth corrections.

(156) "Out-of-State Providers" mean any provider located outside the borders of the State of Oregon:

(a) Contiguous area providers are those located no more than 75 miles from the border of the State of Oregon;

(b) Non-contiguous area providers are those located more than 75 miles from the borders of the State of Oregon.

(157) "Outpatient Hospital Services" mean services that are furnished in a hospital for the care and treatment of an outpatient. For information on outpatient-covered services, see the Division's Hospital Services administrative rules found in chapter 410, division 125.

(158) "Overdue Claim" means a valid claim that is not paid within 45 days of the date it was received.

(159) "Overpayment" means payment(s) made by Authority to a provider in excess of the correct Authority payment amount for a service. Overpayments are subject to repayment to the Authority.

(160) "Overuse" means use of medical goods or services at levels determined by Authority medical staff and/or medical consultants to be medically unnecessary or potentially harmful.

(161) "Paid Provider" means a provider who is issued a provider number for purposes of submitting medical assistance program claims for payment by the Authority.

(162) "Panel" means the Hearing Officer Panel established by section 3, chapter 849, Oregon Laws 1999.

(163) "Payment Authorization" means authorization granted by the responsible agency, office or organization for payment prior or subsequent to the delivery of services, as described in these General Rules and the appropriate program rules. See the individual program rules for services requiring authorization.

(164) "Peer Review Organization (PRO)" means an entity of health care practitioners of services contracted by the State to review services ordered or furnished by other practitioners in the same professional field.

(165) "Pharmaceutical Services" mean services provided by a Pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within his/her scope of practice.

(166) "Pharmacist" means a person licensed to practice pharmacy pursuant to state law.

(167) "Physical Capacity Evaluation" means an objective, directly observed measurement of a person's ability to perform a variety of physical tasks combined with subjective analysis of abilities of the person.

(168) "Physical Therapist" means a person licensed by the relevant State licensing authority to practice Physical Therapy.

(169) "Physical Therapy" means treatment comprising exercise, massage, heat or cold, air, light, water, electricity or sound for the purpose of correcting or alleviating any physical or mental disability, or the performance of tests as an aid to the assessment, diagnosis or treatment of a human being. Physical Therapy shall not include radiology or electrosurgery.

(170) "Physician" means a person licensed to practice medicine pursuant to state law of the state in which he/she practices medicine, or a person licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government. A physician may be an individual licensed under ORS 677 or 685.

(171) "Physician Assistant" means a person licensed as a physician assistant in accordance with ORS 677. Physician assistants provide medical services under the direction and supervision of an Oregon licensed physician according to a practice description approved by the Board of Medical Examiners.

(172) "Physician Services" mean services provided, within the scope of practice as defined under state law, by or under the personal supervision of a physician.

(173) "Podiatric Services" mean services provided within the scope of practice of podiatrists as defined under state law.

(174) "Podiatrist" means a person licensed to practice podiatric medicine pursuant to state law.

(175) "Post-Payment Review" means review of billings and/or other medical information for accuracy, medical appropriateness, level of service or for other reasons subsequent to payment of the claim.

(176) "Practitioner" means a person licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner's license and/or certification.

(177) "Premium Sponsorship" means premium donations made for the benefit of one or more specified Division clients (See 410-120-1390).

(178) "Prepaid Health Plan (PHP)" means a managed health, dental, chemical dependency, or mental health organization that contracts with the Authority on a case managed, prepaid, capitated basis under OHP. PHPs may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Fully Capitated Health Plan (FCHP), Mental Health Organization (MHO), or Physician Care Organization (PCO)

(179) "Primary Care Dentist (PCD)" means a dental practitioner who is responsible for supervising and coordinating initial and primary dental care within their scope of practice for their members.

(180) "Primary Care Provider (PCP)" means any enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients. PCPs initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of medically appropriate client care. A Federally qualified PCP means a physician with a specialty or subspecialty in family medicine, general internal medicine, or pediatric medicine as defined in OAR 410-130-0005. (181) "Prior Authorization (PA)" means payment authorization for specified medical

services or items given by Authority staff, or its contracted agencies prior to provision of the service. A physician referral is not a PA.

(182) "Prioritized List of Health Services" means the listing of conditions and treatment pairs developed by the Health Evidence Review Commission for the purpose of administering OHP.

(183) "Private Duty Nursing Services" mean nursing services provided within the scope of license by a registered nurse or a licensed practical nurse, under the general direction of the patient's physician to an individual who is not in a health care facility.

(184) "Provider" means an individual, facility, institution, corporate entity, or other organization that supplies health services or items, also termed a rendering provider, or bills, obligates and receives reimbursement on behalf of a rendering provider of services, also termed a billing provider (BP). The term provider refers to both rendering providers and BP(s) unless otherwise specified.

(185) "Provider Organization" means a group practice, facility, or organization that is:

(a) An employer of a provider, if the provider is required as a condition of employment to turn over fees to the employer; or

(b) The facility in which the service is provided, if the provider has a contract under which the facility submits claims; or

(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the organization submits the claim; and

(d) Such group practice, facility, or organization is enrolled with the Authority, and payments are made to the group practice, facility or organization;

(e) If such entity solely submits billings on behalf of providers and payments are made to each provider, then the entity is an agent. (See Subparts of Provider Organization).

(186) "Public Health Clinic" means a clinic operated by a county government.

(187) "Public Rates" mean the charge for services and items that providers, including Hospitals and nursing facilities, made to the general public for the same service on the same date as that provided to Authority clients.

(188) "Qualified Medicare Beneficiary (QMB)" means a Medicare beneficiary, as defined by the Social Security Act and its amendments.

(189) "Qualified Medicare and Medicaid Beneficiary (QMM)" means a Medicare beneficiary who is also eligible for Division coverage.

(190) "Quality Improvement" means the efforts to improve the level of performance of a key process or processes in health services or health care.

(191) "Quality Improvement Organization (QIO)" means an entity that has a contract with CMS under Part B of Title XI to perform utilization and quality control review of the health care furnished, or to be furnished, to Medicare and Medicaid clients; formerly known as a Peer Review Organization.

(192) "Radiological Services" mean those professional and technical radiological and other imaging services for the purpose of diagnosis and treatment ordered by a physician or other licensed practitioner of the healing arts within the scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, Hospital, or independent radiological facility.

(193) "Recipient" means a person who is currently eligible for medical assistance (also known as a client).

(194) "Recreational Therapy" means recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).

(195) "Recoupment" means an accounts receivable system that collects money owed by the provider to the Authority by withholding all or a portion of a provider's future payments.

(196) "Referral" means the transfer of total or specified care of a client from one provider to another. As used by the Authority, the term referral also includes a request for a consultation or evaluation or a request or approval of specific services. In the case of clients whose medical care is contracted through a Prepaid Health Plan (PHP), or managed by a Primary Care Physician, a referral is required before non-emergency care is covered by the PHP or the Authority.

(197) "Remittance Advice (RA)" means the automated notice a provider receives explaining payments or other claim actions. It is the only notice sent to providers regarding claim actions.

(198) "Request for Hearing" means a clear expression, in writing, by an individual or representative that the person wishes to appeal a Department or Authority decision or action and wishes to have the decision considered by a higher authority.

(199) "Representative" means an individual who can make OHP-related decisions for a client who is not able to make such decisions themselves.

(200) "Retroactive Medical Eligibility" means eligibility for medical assistance granted to a client retroactive to a date prior to the client's application for medical assistance.

(201) "Ride" means non-emergent medical transportation services for a client either to or from a location where covered services are provided. "Ride" does not include client-reimbursed medical transportation or emergency medical transportation in an ambulance

(202) "Rural" means a geographic area that is 10 or more map miles from a population center of 30,000 people or less.

(203) "Sanction" means an action against providers taken by the Authority in cases of fraud, misuse or abuse of Division requirements.

(204) "School Based Health Service" means a health service required by an Individualized Education Plan (IEP) during a child's education program which addresses physical or mental disabilities as recommended by a physician or other licensed practitioner.

(205) "Service Agreement" means an agreement between the Authority and a specified provider to provide identified services for a specified rate. Service agreements may be limited to services required for the special needs of an identified client. Service agreements do not preclude the requirement for a provider to enroll as a provider.

(206) "Sliding Fee Schedule" means a fee schedule with varying rates established by a provider of health care to make services available to indigent and low-income individuals. The sliding-fee schedule is based on ability to pay.

(207) "Social Worker" means a person licensed by the Board of Clinical Social Workers to practice clinical social work.

(208) "Speech-Language Pathologist" means a person licensed by the Oregon Board of Examiners for Speech Pathology.

(209) "Speech-Language Pathology Services" mean the application of principles, methods, and procedure for the measuring, evaluating, predicting, counseling or instruction related to the development and disorders of speech, voice, or language for the purpose of preventing, habilitating, rehabilitating, or modifying such disorders in individuals or groups of individuals.

(210) "State Facility" means a Hospital or training center operated by the State of Oregon, which provides long-term medical or psychiatric care.

(211) "Subparts (of a Provider Organization)" mean for NPI application, subparts of a health care provider organization would meet the definition of health care provider (45 CFR 160.103) if it were a separate legal entity and if it conducted HIPAA-covered transactions electronically, or has an entity do so on its behalf, could be components of an organization or separate physical locations of an organization.

(212) "Subrogation" means Right of the State to stand in place of the client in the collection of third party resources (TPR).

(213) "Supplemental Security Income (SSI)" means a program available to certain aged and disabled persons which is administered by the Social Security Administration through the Social Security office.

(214) "Surgical Assistant" means a person performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.

(215) "Suspension" means a sanction prohibiting a provider's participation in the medical assistance programs by deactivation of the provider's Authority-assigned billing number for a specified period of time. No payments, Title XIX or State Funds, will be made for services provided during the suspension. The number will be reactivated automatically after the suspension period has elapsed.

(216) "Targeted Case Management (TCM)" means activities that will assist the client in a target group in gaining access to needed medical, social, educational and other services. This includes locating, coordinating, and monitoring necessary and appropriate services. TCM services are often provided by Allied Agency providers.

(217) "Termination" means a sanction prohibiting a provider's participation in the Division's programs by canceling the provider's Authority-assigned billing number and agreement. No payments, Title XIX or State Funds, will be made for services provided after the date of termination. Termination is permanent unless:

(a) The exceptions cited in 42 CFR 1001.221 are met; or

(b) Otherwise stated by the Authority at the time of termination.

(218) "Third Party Liability (TPL), Third Party Resource (TPR) or Third party payer" means a medical or financial resource which, under law,

is available and applicable to pay for medical services and items for a Authority client.

(219) "Transportation" means Medical Transportation.

(220) "Type A Hospital" means a hospital identified by the Office of Rural Health as a Type A hospital.

(221) "Type B AAA" means an AAA administered by a unit or combination of units of general purpose local government for overseeing Medicaid, financial and adult protective services and regulatory programs for the elderly or the elderly and disabled.

(222) "Type B AAA Unit" means a Type B AAA funded by Oregon Project Independence (OPI), Title III — Older Americans Act, and Title XIX of the Social Security Act.

(223) "Type B Hospital" means a hospital identified by the Office of Rural Health as a Type B hospital.

(224) "Urban" means a geographic area that is less than 10 map miles from a population center of 30,000 people or more.

(225) "Urgent Care Services" mean health services that are medically appropriate and immediately required to prevent serious deterioration of a client's health that are a result of unforeseen illness or injury.

(226) "Usual Charge (UC)" means the lesser of the following unless prohibited from billing by federal statute or regulation:

(a) The provider's charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding month's charges;

(b) The provider's lowest charge per unit of service on the same date that is advertised, quoted or posted. The lesser of these applies regardless of the payment source or means of payment;

(c) Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200% of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to third party resources (TPR) are to be considered.

(227) "Utilization Review (UR)" means the process of reviewing, evaluating, and assuring appropriate use of medical resources and services. The review encompasses quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services.

(228) "Valid Claim" means an invoice received by the Division or the appropriate Authority/Department office for payment of covered health care services rendered to an eligible client which:

(a) Can be processed without obtaining additional information from the provider of the goods or services or from a TPR; and

(b) Has been received within the time limitations prescribed in these General Rules (OAR 410 division 120).

(229) "Vision Services" mean provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.

(230) "Volunteer" (for the purposes of NEMT) means an individual selected, trained and under the supervision of DHS who is providing services on behalf of DHS in a non-paid capacity except for incidental expense reimbursement under the DHS Volunteer Program authorized by ORS 409.360

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

Hist.: AFS 5-1981, f. 1-23-81, ef. 3-1-81; AFS 33-1981, f. 6-23-81, ef. 7-1-81; AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82, for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 57-1982, f. 6-28-82, ef. 7-1-82; AFS 81-1982, f. 8-30-82, ef. 9-1-82; AFS 4-1984, f. & ef. 2-1-84; AFS 12-1984, f. 3-16-84, ef. 4-1-84; AFS 13-1984(Temp), f. & ef. 4-2-84; AFS 37-1984, f. 8-30-84, ef. 9-1-84; AFS 24-1985, f. 4-24-85, ef. 6-1-85; AFS 13-1987, f. 3-31-87, ef. 4-1-87; AFS 7-1988, f. & cert. ef. 2-1-88; AFS 69-1988, f. & cert. ef. 12-5-88; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0005; HR 25-1991(Temp), f. & cert. ef. 7-1-91; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; HR 2-1994, f. & cert. ef. 2-1-94; HR 31-1994, f. & cert. ef. 11-1-94; HR 40-1994, f. 12-30-94, cert. ef. 1-1-95; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; HR 21-1997, f. & cert. ef. 10-1-97; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 11-2000, f. & cert. ef. 6-23-00; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 42-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 67-2004, f. 9-14-04, cert. ef. 10-1-04; OMAP 10-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 45-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 24-2007 f. 12-11-07 cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 13-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 11-2011, f. 6-29-11, cert. ef. 7-1-11; DMAP 36-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 11-2012(Temp), f. & cert. ef. 3-16-12 thru 9-11-12; DMAP 28-2012, f. 6-21-12, cert. ef. 7-1-12; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12; DMAP 37-2013(Temp), f. 6-27-13, cert. ef. 7-1-13 thru 12-24-13

410-120-1160

Medical Assistance Benefits and Provider Rules

(1) Providers enrolled with and seeking reimbursement for services through the Division of Medical Assistance Programs (Division) are responsible for compliance with current federal and state laws and regulations governing Medicaid services and reimbursement, including familiarity with periodic law and rule changes. The Division's administrative rules are posted on the Oregon Health Authority (Authority) Web page for the division and its medical assistance programs. It is the provider's responsibility to become familiar with, and abide by, these rules.

(2) The following services are covered to the extent included in the Division client's benefit package of health care services, when medically or dentally appropriate and within the limitations established by the Division and set forth in the Oregon Administrative Rules (OARs) for each category of Medical Services:

(a) Acupuncture services, as described in the Medical-Surgical Services Program provider rules (OAR chapter 410, division 130);

(b) Administrative examinations, as described in the Administrative Examinations and Billing Services Program provider rules (OAR chapter 410, division 150);

(c) Substance Use Disorder treatment services:

(A) The Division covers Substance Use Disorder inpatient treatment services for medically managed intensive inpatient detoxification when provided in an acute care hospital and when hospitalization is considered medically appropriate. The Division covers Medically Monitored detoxification and Clinically Managed detoxification provided in a free standing detoxification center or an appropriately licensed SUDs residential treatment facility when considered medically appropriate;

(B) The Division covers non-hospital Substance Use Disorder treatment and recovery services on a residential or outpatient basis. For information to access these services, contact the client's PHP or CCO if enrolled, the community mental health program (CMHP), an outpatient Substance Use Disorder treatment provider, the residential treatment program or the Addictions and Mental Health Division AMH;

(C) The Division does not cover residential level of care provided in an inpatient hospital setting for Substance Use Disorder treatment and recovery;

(d) Ambulatory surgical center services, as described in the Medical-Surgical Services Program provider rules (OAR 410 division 130);

(e) Anesthesia services, as described in the Medical-Surgical Services Program provider rules (OAR chapter 410, division 130);

(f) Audiology services, as described in the Speech-Language Pathology, Audiology and Hearing Aid Services Program provider rules (OAR chapter 410, division 129);

(g) Chiropractic services, as described in the Medical-Surgical Services Program provider rules (OAR chapter 410, division 130);

(h) Dental services, as described in the Dental/Denturist Services Program provider rules (OAR chapter 410, division 123);

(i) Early and periodic screening, diagnosis and treatment services (EPSDT, Medicheck for children and teens), are covered for individuals under 21 years of age as set forth in the individual program provider rules. The Division may authorize services in excess of limitations established in the OARs when it is medically appropriate to treat a condition that is identified as the result of an EPSDT screening;

(j) Family planning services, as described in the Medical-Surgical Services Program provider rules (OAR chapter 410, division 130);

(k) Federally qualified health centers and rural health clinics, as described in the Federally Qualified Health Center and Rural Health Clinic Program provider rules (OAR chapter 410, division 147);

(l) Home and community-based waiver services, as described in the Authority and the Department's OARs of Children, Adults and Families Division (CAF), Addictions and Mental Health Division (AMH), and Seniors and People with Disabilities Division (SPD);

(m) Home enteral/parenteral nutrition and IV services, as described in the Home Enteral/Parenteral Nutrition and IV Services Program rules (OAR chapter 410, division 148), and related Durable Medical Equipment. Prosthetics, Orthotics and Supplies Program rules (OAR chapter 410, division 122) and Pharmaceutical Services Program rules (OAR chapter 410, division 121);

(n) Home health services, as described in the Home Health Services Program rules (OAR chapter 410, division 127);

(o) Hospice services, as described in the Hospice Services Program rules (OAR chapter 410, division 142);

(p) Indian health services or tribal facility, as described in The Indian Health Care Improvement Act and its Amendments (Public Law 102-573),

and the Division's American Indian/Alaska Native Program rules (OAR chapter 410, division 146);

(q) Inpatient hospital services, as described in the Hospital Services Program rules (OAR chapter 410, division 125);

(r) Laboratory services, as described in the Hospital Services Program rules (OAR chapter 410, division 125) and the Medical-Surgical Services Program rules (OAR chapter 410, division 130);

(s) Licensed direct- entry midwife services, as described in the Medical-Surgical Services Program rules (OAR chapter 410, division 130);

(t) Maternity case management, as described in the Medical-Surgical Services Program rules (OAR chapter 410, division 130);

(u) Medical equipment and supplies, as described in the Hospital Services Program, Medical-Surgical Services Program, DMEPOS Program, Home Health Care Services Program, Home Enteral/Parenteral Nutrition and IV Services Program and other rules;

(v) When a client's Benefit Package includes mental health, the mental health services provided will be based on the Oregon Health Services Commission's Prioritized List of Health Services.;

(w) Naturopathic services, as described in the Medical-Surgical Services Program rules (OAR chapter 410, division 130);

(x) Nutritional counseling as described in the Medical/Surgical Services Program rules (OAR chapter 410, division 130);

(y) Occupational therapy, as described in the Physical and Occupational Therapy Services Program rules (OAR chapter 410, division 131);

(z) Organ transplant services, as described in the Transplant Services Program rules (OAR chapter 410, division 124);

(aa) Outpatient hospital services, including clinic services, emergency department services, physical and occupational therapy services, and any other outpatient hospital services provided by and in a hospital, as described in the Hospital Services Program rules (OAR chapter 410, division 125);

(bb) Physician, podiatrist, nurse Practitioner and licensed physician assistant services, as described in the Medical-Surgical Services Program rules (OAR chapter 410, division 130);

(cc) Physical therapy, as described in the Physical and Occupational Therapy and the Hospital Services Program rules (OAR chapter 410, division 131);

(dd) Post-hospital extended care benefit, as described in OAR chapter 410, division 120 and 141 and Seniors and People with Disabilities (SPD) program rules;

(ee) Prescription drugs, including home enteral and parenteral nutritional services and home intravenous services, as described in the Pharmaceutical Services Program (OAR chapter 410, division 121), the Home Enteral/Parenteral Nutrition and IV Services Program (OAR chapter 410, division 148) and the Hospital Services Program rules (OAR chapter 410, division 125);

(ff) Preventive services, as described in the Medical-Surgical Services (OAR chapter 410, division 130) and the Dental/Denturist Services Program rules (OAR chapter 410, division 123) and prevention guidelines associated with the Health Service Commission's Prioritized List of Health Services (OAR 410-141-0520);

(gg) Private duty nursing, as described in the Private Duty Nursing Services Program rules (OAR chapter 410, division 132);

(hh) Radiology and imaging services, as described in the Medical-Surgical Services Program rules (OAR chapter 410, division 130), the Hospital Services Program rules (OAR chapter 410, division 125), and Dental Services Program rules (OAR chapter 410, division 123);

(ii) Rural health clinic services, as described in the Federally Qualified Health Center and Rural Health Clinic Program rules (OAR chapter 410, division 147);

(jj) School-based health services, as described in the School-Based Health Services Program rules (OAR chapter 410, division 133);

(kk) Speech and language therapy as described in the Speech-Language Pathology, Audiology and Hearing Aid Services Program rules (OAR chapter 410, division 129) and Hospital Services Program rules (OAR chapter 410, division 125);

(ll) Transportation necessary to access a covered medical service or item, as described in the Medical Transportation Program rules (OAR chapter 410, division 136);

(mm) Vision services as described in the Visual Services Program rules (OAR chapter 410, division 140).

(3) Other Authority or Department Divisions, units or Offices, including Vocational Rehabilitation, AMH, and SPD may offer services to Medicaid eligible clients, which are not reimbursed by or available through the Division of Medical Assistance Programs.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025, 414.065 & 414.705
Hist.: PWC 683, f. 7-19-74, ef. 8-11-74; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 14-1979, f. 6-29-79, ef. 7-1-79; AFS 73-1980(Temp), f. & ef. 10-1-80; AFS 5-1981, f. 1-23-81, ef. 3-1-81; AFS 71-1981, f. 9-30-81, ef. 10-1-81; Renumbered from 461-013-0000, AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 94-1982(Temp), f. & ef. 10-18-82; AFS 103-1982, f. & ef. 11-1-82; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 42-1983, f. 9-2-83, ef. 10-1-83; AFS 62-1983, f. 12-19-83, ef. 1-1-84; AFS 4-1984, f. & ef. 2-1-84; AFS 12-1984, f. 3-16-84, ef. 4-1-84; AFS 25-1984, f. 6-8-84, ef. 7-1-84; AFS 14-1985, f. 3-14-85, ef. 4-1-85; AFS 53-1985, f. 9-20-85, ef. 10-1-85; AFS 67-1986(Temp), f. 9-26-86, ef. 10-1-86; AFS 76-1986(Temp), f. & ef. 12-8-86; AFS 16-1987(Temp), f. & ef. 4-1-87; AFS 17-1987, f. 5-4-87, ef. 6-1-87; AFS 32-1987, f. 7-22-87, ef. 8-1-87; AFS 6-1988, f. & cert. ef. 2-1-88; AFS 51-1988(Temp), f. & cert. ef. 8-2-88; AFS 58-1988(Temp), f. & cert. ef. 9-27-88; AFS 69-1988, f. & cert. ef. 12-5-88; AFS 70-1988, f. & cert. ef. 12-7-88; AFS 4-1989, f. 1-31-89, cert. ef. 2-1-89; AFS 8-1989(Temp), f. 2-24-89, cert. ef. 3-1-89; AFS 14-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 47-1989, f. & cert. ef. 8-24-89; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0102; HR 5-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 19-1990, f. & cert. ef. 7-9-90; HR 32-1990, f. 9-24-90, cert. ef. 10-1-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 27-1992(Temp), f. & cert. ef. 9-1-92; HR 33-1992, f. 10-30-92, cert. ef. 11-1-92; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0440; HR 2-1994, f. & cert. ef. 2-1-94; HR 40-1994, f. 12-30-94, cert. ef. 1-1-95; HR 21-1997, f. & cert. ef. 10-1-97; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 67-2004, f. 9-14-04, cert. ef. 10-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 36-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12; DMAP 37-2013(Temp), f. 6-27-13, cert. ef. 7-1-13 thru 12-24-13

410-120-1200
Excluded Services and Limitations

(1) Certain services or items are not covered under any program or for any group of (1) Certain services or items are not covered under any program or for any group of eligible clients. If the client accepts financial responsibility for a non-covered service, payment is a matter between the provider and the client subject to the requirements of OAR 410-120-1280.

(2) The Division of Medical Assistance Programs (Division) shall make no payment for any expense incurred for any of the following services or items that are:

(a) Not expected to significantly improve the basic health status of the client as determined by Division staff, or its contracted entities, for example, the Division's Medical Director, medical consultants, dental consultants or Quality Improvement Organizations (QIO);

(b) Not reasonable or necessary for the diagnosis and treatment of disability, illness, or injury;

(c) Determined not medically or dentally appropriate by Division staff or authorized representatives, including Acumentra or any contracted utilization review organization;

(d) Not properly prescribed as required by law or administrative rule by a licensed practitioner practicing within his or her scope of practice or licensure;

(e) For routine checkups or examinations for individuals age 21 or older in connection with participation, enrollment, or attendance in a program or activity not related to the improvement of health and rehabilitation of the client. Examples include exams for employment or insurance purposes;

(f) Provided by friends or relatives of eligible clients or members of his or her household, except when the friend, relative or household member:

(A) Is a health professional, acting in a professional capacity; or

(B) Is directly employed by the client under the Department of Human Services (Department) Seniors and People with Disabilities Division (SPD) Home and Community Based Waiver or the SPD administrative rules, OAR 411-034-000 through 411-034-0090, governing Personal Care Services covered by the State Plan; or

(C) Is directly employed by the client under the Children, Adults and Families Division (CAF) administrative rules, OAR 413-090-0100 through 413-090-0220, for services to children in the care and custody of the Department who have special needs inconsistent with their ages. A family member of a minor client (under the age of 18) must not be legally responsible for the client in order to be a provider of personal care services;

(g) For services or items provided to a client who is in the custody of a law enforcement agency or an inmate of a non-medical public institution, including juveniles in detention facilities, except such services as designated by federal statute or regulation as permissible for coverage under the Division's administrative rules;

(h) Needed for purchase, repair or replacement of materials or equipment caused by adverse actions of clients to personally owned goods or equipment or to items or equipment that the Division rented or purchased;

(i) Related to a non-covered service; some exceptions are identified in the individual provider rules. If the Division determines the provision of a service related to a non-covered service is cost-effective, the related medical service may, at the discretion of the Division and with Division prior authorization (PA), be covered;

(j) Considered experimental or investigational, including clinical trials and demonstration projects, or which deviate from acceptable and customary standards of medical practice or for which there is insufficient outcome data to indicate efficacy;

(k) Identified in the appropriate program rules including the Division's Hospital Services Program administrative rules, Revenue Codes Section, as non-covered services.

(l) Requested by or for a client whom the Division has determined to be non-compliant with treatment and who is unlikely to benefit from additional related, identical, or similar services;

(m) For copying or preparing records or documents that except those Administrative Medical Reports requested by the branch offices or the Division for casework planning or eligibility determinations;

(n) Whose primary intent is to improve appearances;

(o) Similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same;

(p) For the purpose of establishing or reestablishing fertility or pregnancy or for the treatment of sexual dysfunction, including impotence,

(q) Items or services which are for the convenience of the client and are not medically or dentally appropriate;

(r) The collection, processing and storage of autologous blood or blood from selected donors unless a physician certifies that the use of autologous blood or blood from a selected donor is medically appropriate and surgery is scheduled;

(s) Educational or training classes that are not medically appropriate (Lamaze classes, for example);

(t) Outpatient social services except maternity case management services and other social services described as covered in the individual provider rules;

(u) Plasma infusions for treatment of Multiple Sclerosis;

(v) Post-mortem exams or burial costs, or other services subsequent to the death of a client;

(w) Radial keratotomies;

(x) Recreational therapy;

(y) Telephone calls, except for:

(A) Tobacco cessation counseling, as described in OAR 410-130-0190;

(B) Maternity case management as described in OAR 410-130-0595;

(C) Telemedicine as described in OAR 410-130-0610; and

(D) Services specifically identified as allowable for telephonic delivery when appropriate in the mental health and substance use disorder procedure code and reimbursement rates published by the Addiction and Mental Health Division;

(z) Transsexual surgery or any related services or items;

(aa) Weight loss programs, including, but not limited to, Optifast, Nutrisystem, and other similar programs. Food supplements will not be authorized for use in weight loss;

(bb) Whole blood (whole blood is available at no cost from the Red Cross); the processing, storage and costs of administering whole blood are covered;

(cc) Immunizations prescribed for foreign travel;

(dd) Services that are requested or ordered but not provided (i.e., an appointment which the client fails to keep or an item of equipment which has not been provided to the client);

(ee) Transportation to meet a client's personal choice of a provider;

(ff) Pain center evaluation and treatment for unfunded condition/treatment pairs on the Oregon Health Services Commission's Prioritized List of Health Services;

(gg) Alcoholics Anonymous (AA) and other self help programs;

(hh) Medicare Part D covered prescription drugs or classes of drugs, and any cost sharing for those drugs, for Medicare-Medicaid Fully Dual Eligible clients, even if the Fully Dual Eligible client is not enrolled in a Medicare Part D plan. See OAR 410-120-1210 for benefit package.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065, 414.025

Hist.: PWC 683, f. 7-19-74, ef. 8-11-74; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76, Renumbered from 461-013-0030; AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 103-1982, f. & ef. 11-1-82; AFS 15-1983(Temp), f. & ef. 4-20-83; AFS 31-1983(Temp), f. 6-30-83, ef. 7-1-83; AFS 43-1983, f. 9-2-83, ef. 10-1-83; AFS 61-1983, f. 12-19-83, ef. 1-1-84; AFS 24-1985, f. 4-24-85, ef. 6-1-85; AFS 57-1986, f. 7-25-86, ef. 8-1-86; AFS 78-1986(Temp), f. 12-16-86, ef. 1-1-87; AFS 10-1987, f. 2-27-87, ef. 3-1-87; AFS 29-1987(Temp), f. 7-15-87, ef. 7-17-87; AFS 54-1987, f. 10-29-87, ef. 11-1-87; AFS 51-1988(Temp), f. & cert. ef. 8-2-88; AFS 53-1988(Temp), f. 8-23-88, cert. ef. 9-1-88; AFS 58-1988(Temp), f. & cert. ef. 9-27-88; AFS 70-1988, f. & cert. ef. 12-7-88; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0055; 461-013-0103, 461-013-0109 & 461-013-0112; HR 5-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 19-1990, f. & cert. ef. 7-9-90; HR 23-1990(Temp), f. & cert. ef. 7-20-90; HR 32-1990, f. 9-24-90, cert. ef. 10-1-90; HR 27-1991 (Temp), f. & cert. ef. 7-1-91; HR 41-1991, f. & cert. ef. 10-1-91; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0420, 410-120-0460 & 410-120-0480; HR 2-1994, f. & cert. ef. 2-1-94; HR 31-1994, f. & cert. ef. 11-1-94; HR 40-1994, f. 12-30-94, cert. ef. 1-1-95; HR 6-1996, f. 5-31-96 & cert. ef. 6-1-96; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; HR 21-1997, f. & cert. ef. 10-1-97; OMAP 12-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 22-2002, f. 6-14-02 cert. ef. 7-1-02; OMAP 42-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 8-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 17-2003(Temp), f. 3-13-03, cert. ef. 3-14-03 thru 8-15-03; OMAP 46-2003(Temp), f. & cert. ef. 7-1-03 thru 12-15-03; OMAP 56-2003, f. 8-28-03, cert. ef. 9-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 10-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 24-2007, f. 12-11-07 cert. ef. 1-1-08; DMAP 15-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 38-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 39-2010, f. 12-28-10, cert. ef. 1-1-11; DMAP 36-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 37-2013(Temp), f. 6-27-13, cert. ef. 7-1-13 thru 12-24-13

410-120-1210

Medical Assistance Benefit Packages and Delivery System

(1) The services clients are eligible to receive are based upon the benefit package for which they are eligible. Not all packages receive the same benefits.

(2) The Division of Medical Assistance Programs (Division) benefit package description, codes, eligibility criteria, coverage, limitations and exclusions are identified in these rules.

(3) The limitations and exclusions listed here are in addition to those described in OAR 410-120-1200 and in each of the chapter 410 OARs.

(4) Benefit package descriptions:

(a) Oregon Health Plan (OHP) Plus:

(A) Benefit package identifier: BMH

(B) Eligibility criteria:As defined in federal regulations and in the 1115 OHP waiver demonstration, a client is categorically eligible for medical assistance if he or she is eligible under a federally defined mandatory, selected, optional Medicaid program or the Children's Health Insurance Program (CHIP) and also meets Oregon Health Authority (Authority) adopted income and other eligibility criteria.

(C) Coverage includes:

(i) Services above the funding line on the Health Services Commission's (HSC) Prioritized List of Health Services, (OAR 410-141-0480 through 410-141-0520);

(ii) Ancillary services, (OAR 410-141-0480);

(iii) Substance use disorder treatment and recovery services provided through local Substance use disorder treatment and recovery providers;

(iv) Mental health services based on the HSC Prioritized List of Health Services, to be provided through Community Mental Health Programs or their subcontractors;

(v) Hospice;

(vi) Post-hospital extended care benefit, up to a 20-day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043), or by the Fully Capitated Health Plan (FCHP) for clients enrolled in an FCHP;

(vii) Cost sharing (e.g., copayments) may apply to some covered services;

(B) Limitations: The following services have limited coverage for non pregnant adults age 21 and older. (Refer to the cited OAR chapters and divisions for details):

(i) Selected dental (OAR chapter 410, division 123);

(ii) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140);

(b) OHP Standard:

(A) Benefit Package identifier code: KIT;

(B) Eligiblity criteria: Adults and childless couples who are eligible through the 1115 Medicaid expansion waiver and meet Authority-adopted income and other eligibility criteria; the Department identifies these clients through the program acronym, OHP-OPU;

(C) Coverage includes:

(i) Services above the funding line on the HSC Prioritized List, (OAR 410-141-0480 through 410-141-0520);

(ii) Ancillary services, (OAR 410-141-0480);

(iii) Outpatient substance use disorder treatment and recovery services provided through local substance use disorder treatment and recovery providers;

(iv) Outpatient mental health services based on the HSC Prioritized List of Health Services, to be provided through Community Mental Health Programs or their subcontractors;

(v) Hospice;

(vi) Post-hospital extended care benefit, up to a 20-day stay in a nursing facility for non-Medicare Division clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires prior authorization by pre-admission screening (OAR 411-070-0043) or by the Fully Capitated Health Plan (FCHP) for clients enrolled in an FCHP.

(B) Limitations: The following services have limited coverage (Refer to the cited OAR chapters and divisions for details):

(i) Selected dental (OAR chapter 410, division 123);

(ii) Selected durable medical equipment and medical supplies (OAR chapter 410, division 122 and 130);

(iii) Selected home enteral/parenteral services (OAR chapter 410, division 148);

(iv) Other limitations as identified in individual Division program administrative rules.

(C) Exclusions: The following services are not covered. Refer to the cited OAR chapters and divisions for details:

(i) Acupuncture services, except when provided for substance use disorder treatment and recovery services(OAR chapter 410, division 130);

(ii) Chiropractic and osteopathic manipulation services (OAR chapter 410, division 130);

(iii) Hearing aids and related services (i.e., exams for the sole purpose of determining the need for or the type of hearing aid), (OAR chapter 410, division 129);

(iv) Home health services (OAR chapter 410, division 127), except when related to limited EPIV services (OAR chapter 410, division 148);

(v) Non-emergency medical transportation (OAR chapter 410, division 136);

(vi) Occupational therapy services (OAR chapter 410, division 131);

(vii) Physical therapy services (OAR chapter 410, division 131);

(viii) Private duty nursing services (OAR chapter 410, division 132), except when related to limited EPIV services;

(ix) Speech and language therapy services (OAR chapter 410, division 129);

(x) Vision services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140);

(xi) Other limitations as identified in individual Division program administrative rules, chapter 410.

(c) OHP with Limited Drug:

(A) Benefit Package identifier: BMM, BMD;

(B) Eligibility criteria: Eligible clients are eligible for Medicare and Medicaid benefits;

(C) Coverage includes:

(i) Services covered by Medicare and OHP Plus as described in section (4) of these rules;

(D) Limitations:

(i) The same as OHP Plus, as described in section (4) of these rules;

(ii) Drugs excluded from Medicare Part D coverage that are also covered under the medical assistance programs, subject to applicable limitations for covered prescription drugs (Refer to OAR chapter 410, division 121 for specific limitations). These drugs include but are not limited to:

(I) Over-the-counter (OTC) drugs;

(II) Barbiturates(except for dual eligible individuals when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D will cover those indications).

(E) Exclusions: Drugs or classes of drugs covered by Medicare Part D Prescription Drug.

(F) Payment for services is limited to the Medicaid allowed payment less the Medicare payment up to the amount of co-insurance and deductible;

(G) Cost sharing may apply to some covered services, however, cost sharing related to Medicare Part D is not covered since drugs covered by Part D are excluded from the benefit package;

(d) Qualified Medicare Beneficiary (QMB)-Only:

(A) Benefit Package identifier code MED:

(B) Eligibility criteria: Eligibleclients are Medicare Part A and B beneficiaries who have limited income but do not meet the income standard for full medical assistance coverage.

(C) Coverage: Is limited to the co-insurance or deductible for the Medicare service. Payment is based on the Medicaid allowed payment less the Medicare payment up to the amount of co-insurance and deductible, but no more than the Medicare allowable;

(D) Providers may not bill QMB-only clients for the deductible and coinsurance amounts due for services that are covered by Medicare.

(e) Citizen/Alien-Waived Emergency Medical (CAWEM):

(A) Benefit Package identifier CWM:

(B) Eligibility criteria: Eligible clientsare non-qualified aliens that are not eligible for other Medicaid programs pursuant to Oregon Administrative Rules (OAR) 461-135-1070;

(C) Coverage is limited to:

(i) Emergency medical services as defined by 42 CFR 440.255. Sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part (the "prudent layperson standard" does not apply to the CAWEM emergency definition);

(ii) Labor and Delivery.

(D) Exclusions: The following services are not covered, even if they are sought as emergency services:

(i) Prenatal or postpartum care;

(ii) Sterilization;

(iii) Family Planning;

(iv) Preventive care;

(v) Organ transplants and transplant-related services;

(vi) Chemotherapy;

(vii) Hospice;

(viii) Home health;

(ix) Private duty nursing;

(x) Dialysis;

(xi) Dental services provided outside of an emergency department hospital setting;

(xii) Outpatient drugs or over-the-counter products;

(xiii) Non-emergency medical transportation;

(xiv) Therapy services;

(xv) Durable medical equipment and medical supplies;

(xvi) Rehabilitation services.

(f) CAWEM Plus-CHIP Prenatal coverage for CAWEM (benefit code CWX) — refer to OAR 410-120-0030 for coverage.

(5) Division clients are enrolled for covered health services to be delivered through one of the following means:

(a) Coordinated Care Organization (CCO):

(A) These clients are enrolled in a CCO that provides integrated and coordinated health care;

(B) CCO services are obtained from the CCO or by referral from the CCO that is responsible for the provision and reimbursement for physical health, substance use disorder treatment and recovery, mental health services or dental care.

(b) Prepaid Health Plan (PHP):

(A) These clients are enrolled in a PHP for their medical, dental or mental health care;

(B) Most non-emergency services are obtained from the PHP or require a referral from the PHP that is responsible for the provision and reimbursement for the medical, dental or mental health service;

(c) Physician Care Organization (PCO):

(A) These clients are enrolled in a PCO for their medical care;

(B) Inpatient hospital services are not the responsibility of the PCO and are governed by the Fee-for-Service Hospital Services Program rule (OAR 410 Division 125).

(d) Primary Care Managers (PCM):

(A) These clients are enrolled with a PCM for their medical care;

(B) Most non-emergency services provided to clients enrolled with a PCM require referral from the PCM.

(c) Fee-for-service (FFS):

(A) These clients are not enrolled in a CCO, PHP, PCO or assigned to a PCM;

(B) Subject to limitations and restrictions in individual program rules, the client can receive health care from any Division-enrolled provider that accepts FFS clients. The provider will bill the Division directly for any covered service and will receive a fee for the service provided.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025, 414.065, 414.329, 414.705, 414.706, 414.707, 414.708, 414.710
Hist.: OMAP 46-2003(Temp), f. & cert. ef. 7-1-03 thru 12-15-03; OMAP 56-2003, f. 8-28-03, cert. ef. 9-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 38-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 36-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 49-2012, f. 10-31-12, cert. ef. 11-1-12; DMAP 63-2012(Temp), f. 12-27-12, cert. ef. 1-1-13 thru 6-29-13; DMAP 31-2013, f. & cert. ef. 6-27-13; DMAP 37-2013(Temp), f. 6-27-13, cert. ef. 7-1-13 thru 12-24-13

410-120-1855
Client's Rights and Responsibilities

(1) Division of Medical Assistance Programs (Division) clients shall have the following rights:

(a) To be treated with dignity and respect;

(b) To be treated by providers the same as other people seeking health care benefits to which they are entitled;

(c) To refer oneself directly to mental health, substance use disorder or family planning services without getting a referral from a Primary Care Practitioner (PCP) or other provider;

(d) To have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines;

(e) To be actively involved in the development of his/her treatment plan;

(f) To be given information about his/her condition and covered and non-covered services to allow an informed decision about proposed treatment(s);

(g) To consent to treatment or refuse services, and be told the consequences of that decision, except for court ordered services;

(h) To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;

(i) To have written materials explained in a manner that is understandable to the Division client;

(j) To receive necessary and reasonable services to diagnose the presenting condition;

(k) To receive Division covered services that meet generally accepted standards of practice and are medically appropriate;

(l) To obtain covered preventive services;

(m) To receive a referral to specialty providers for medically appropriate covered services;

(n) To have a clinical record maintained which documents conditions, services received, and referrals made;

(o) To have access to one's own clinical record, unless restricted by statute;

(p) To transfer of a copy of his/her clinical record to another provider;

(q) To execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, substance use disorder or mental health treatment and the right to execute directives and powers of attorney for health care established under ORS 127 as amended by the Oregon Legislative Assembly 1993 and the OBRA 1990 — Patient Self-Determination Act;

(r) To receive written notices before a denial of, or change in, a benefit or service level is made, unless such notice is not required by federal or state regulations;

(s) To know how to make a Complaint, Grievance or Appeal with the Division and receive a response as defined in OAR 410-120-1860 and 410120-1865;

(t) To request an Administrative Hearing with the Oregon Health Authority (Authority);

(u) To receive a notice of an appointment cancellation in a timely manner;

(v) To receive adequate notice of Authority privacy practices.

(2) Division clients shall have the following responsibilities:

(a) To treat the providers and clinic's staff with respect;

(b) To be on time for appointments made with providers and to call in advance either to cancel if unable to keep the appointment or if he/she expects to be late;

(c) To seek periodic health exams and preventive services from his/her PCP or clinic;

(d) To use his/her PCP or clinic for diagnostic and other care except in an Emergency;

(e) To obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;

(f) To use emergency services appropriately;

(g) To give accurate information for inclusion in the clinical record;

(h) To help the provider or clinic obtain clinical records from other providers which may include signing an authorization for release of information;

(i) To ask questions about conditions, treatments and other issues related to his/her care that is not understood;

(j) To use information to make informed decisions about treatment before it is given;

(k) To help in the creation of a treatment plan with the provider;

(l) To follow prescribed agreed upon treatment plans;

(m) To tell the provider that his or her health care is covered with the Division before services are received and, if requested, to show the provider the OMAP Medical Care Identification form;

(n) To tell the Department worker of a change of address or phone number;

(o) To tell the Department worker if the Division client becomes pregnant and to notify the Department worker of the birth of the Division client's child;

(p) To tell the Department worker if any family members move in or out of the household;

(q) To tell the Department worker and provider(s) if there is any other insurance available, changes of insurance coverage including Private Health Insurance (PHI) according to OAR 410-120-1960, and to complete required periodic documentation of such insurance coverage in a timely manner;

(r) To pay for non-Covered Services under the provisions described in OAR 410-120-1200 and 410-120-1280;

(s) To pay the monthly OHP premium on time if so required;

(t) To assist the Division in pursuing any TPR available and to pay the Division the amount of benefits it paid for an injury from any recovery received from that injury;

(u) To bring issues, or Complaints or Grievances to the attention of the Division; and

(v) To sign an authorization for release of medical information so that the Authority can get information which is pertinent and needed to respond to an Administrative Hearing request in an effective and efficient manner.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065
Hist.: OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 37-2013(Temp), f. 6-27-13, cert. ef. 7-1-13 thru 12-24-13

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Rule Caption: Add Dental Care Organization (DCO) language for dental integration into CCO's
Adm. Order No.: DMAP 38-2013(Temp)
Filed with Sec. of State: 7-8-2013
Certified to be Effective: 7-9-13 thru 1-5-14
Notice Publication Date:
Rules Amended: 410-141-3060, 410-141-3080, 410-141-3220, 410-141-3420
Subject: The Division needs to amend these rules to incorporate language related to dental services being integrated into the Coordinated Care Organizations (CCO). Changes have been made for clarity of rule language; the addition of effective dates, behavioral health and Dental Care Organization.
Rules Coordinator: Cheryl Peters—(503) 945-6527

410-141-3060
Enrollment Requirements in a CCO

(1) A client who is eligible for or receiving health services must enroll in a CCO as required by ORS 414.631, except as provided in 414.631(2), (3), (4), and (5) and 414.632(2) or exempted by this rule.

(2) If, upon application or redetermination, a client does not select a CCO, the Authority shall enroll the client and the client's household in a CCO that has adequate health care access and capacity.

(3) For existing members of a PHP that has transitioned to a CCO, the Authority shall enroll those members in the CCO when the Authority certifies and contracts with the CCO. The Authority shall provide notice to the enrollees 30 days before the effective date.

(4) Existing members of a PHP that is on the path to becoming a CCO shall retain those members. The Authority shall enroll those members in the CCO when certification and contracting are complete. The Authority shall provide notice to the clients 30 days before the effective date.

(5) Unless otherwise exempted by sections (17) and (18) of this rule, existing clients receiving their physical health care services on a fee-for-service basis shall enroll in a CCO serving their area that has adequate health care access and capacity. They must enroll by November 1, 2012.

The Authority shall send a notice to the clients 30 days before the effective date.

(6) The following apply to clients receiving physical health care services on a fee-for-service basis but managed or coordinated behavioral health services:

(a) The Authority shall enroll the client in a CCO that is serving the client's area before November 1, 2012;

(b) The client shall receive their behavioral health care services from that CCO;

(c) The client shall continue to receive their physical health care services on a fee-for-service basis; and

(d) On or after November 1, 2012, the Authority shall enroll the client in a CCO for both physical health and behavioral health care services, unless otherwise exempted by sections (17) and (18) of this rule.

(e) On or after November 1, 2012, for the client exempt from coordinated physical health services by sections (17) and (18) shall receive managed or coordinated behavioral health services from a CCO or MHO.

(7) The following apply to clients enrolled in Medicare:

(a) A client may enroll in a CCO regardless of whether they are enrolled in Medicare Advantage;

(b) A client enrolled in Medicare Advantage, whether or not they pay their own premium, may enroll in a CCO, even if the CCO does not have a corresponding Medicare Advantage plan.

(c) A client may enroll with a CCO, even if the client withdrew from that CCO's Medicare Advantage plan. The CCO shall accept the client's enrollment if the CCO has adequate health access and capacity;

(d) A client may enroll with a CCO, even if the client is enrolled in Medicare Advantage with another entity.

(8) From August 1, 2012, until November 1, 2012, enrollment is required in service areas with adequate health care access and capacity to provide health care services through a CCO or PHP. The following outlines the priority of enrollment during this period in service areas where enrollment is required:

(a) Priority 1: The client must enroll in a CCO that serves that area and has adequate health care access and capacity;

(b) Priority 2: The client must enroll in a PHP if:

(A) A PHP serves an area that a CCO does not serve; or

(B) A PHP serves an area that a CCO serves, but the CCO has inadequate health care access and capacity to accept new members;

(c) Priority 3: The client shall receive services on a fee-for-service basis.

(9) From August 1, 2012, until November 1, 2012, enrollment is voluntary in service areas without adequate access and capacity to provide health care services through a CCO or PHP. If a client decides to enroll in a CCO or PHP, the priority of enrollment in section (8) applies.

(10) On or after November 1, 2012, CCO enrollment is required in all areas. The following outlines the priority of options to enroll in all service areas:

(a) Priority 1: The client must enroll in a CCO that serves that area and has adequate health care access and capacity;

(b) Priority 2: The client must enroll in a PHP on the path to becoming a CCO if:

(A) The PHP serves an area that a CCO does not serve; or

(B) The PHP serves an area that a CCO serves, but the CCO has inadequate health care services capacity to accept new members;

(c) Priority 3: The client must enroll in a PHP that is not on the path to becoming a CCO if:

(A) The PHP serves an area that a CCO does not serve; or

(B) The PHP serves an area that a CCO serves, but the CCO has inadequate health care access or capacity to accept new members;

(d) Priority 4: The client shall receive physical services on a fee-for-service basis.

(11) On or after July 1, 2013, a client must enroll in a CCO or managed dental care organization (DCO) in a service area where a CCO or DCO has adequate dental care access and capacity, and a CCO or DCO is open to enrollment. (13) If a client receives physical health care through a PHP, PCM or on a fee-for-service basis, under circumstances allowed by this rule, the client must enroll in a CCO or mental (behavioral) health organization (MHO) in a service area where MHO enrollment is required. The following determines if a service area requires CCO or MHO enrollment:

(a) CCO: The service area has adequate CCO behavioral health care access and capacity;

(b) MHO: A CCO does not serve in the area; or

(c) MHO: A CCO serves the area, but the CCO has inadequate health care access and capacity to accept new members:

(12) From August 1, 2012, until November 1, 2012, if a service area changes from required enrollment to voluntary enrollment, the member shall remain with the PHP for the remainder of their eligibility period or until the Authority or Department redetermines eligibility, whichever comes sooner, unless otherwise eligible to disenroll pursuant to OAR 410-41-3080.

(13) At the time of application or recertification, the primary person in the household shall select the CCO on behalf of all household members on the same household case. If the client is not able to choose a CCO, the client's representative shall make the selection.

(14) The Department or OYA shall select the CCO for a child in the legal custody of the Department or OYA, except for children in subsidized adoptions.

(15) The following populations are exempt from CCO enrollment:

(a) Populations expressly exempted by ORS 414.631(2) (a), (b) and (c), which includes:

(A) Persons who are non-citizens who are eligible for labor and delivery services and emergency treatment services;

(B) Persons who are American Indian and Alaskan Native beneficiaries; and

(C) Persons who are dually eligible for Medicare and Medicaid and enrolled in a program of all-inclusive care for the elderly.

(b) Newly eligible clients are exempt from enrollment with a CCO if the client became eligible when admitted as an inpatient in a hospital. The client shall receive health care services on a fee-for-service basis only until the hospital discharges the client. The client is not exempt from enrollment in a DCO. The client is not exempt from enrollment in a DCO.

(c) Children in the legal custody of the Department or OYA where the child is expected to be in a substitute care placement for less than 30 calendar days, unless:

(A) Access to health care on a fee-for-service basis is not available; or

(B) Enrollment would preserve continuity of care.

(d) Clients with major medical health insurance coverage, also known as third party liability, except as provided in OAR 410-141-3050;

(e) Clients receiving prenatal services through the Citizen/Alien Waivered-Emergency Medical program; and

(f) Clients receiving premium assistance through the Specified Low-Income Medicare Beneficiary, Qualified Individuals, Qualified Disabled Working Individuals and Qualified Medicare Beneficiary programs.

(16) The following populations are exempt from CCO enrollment until specified below:

(a) From August 1, 2012, until November 1, 2012, children under 19 years of age who are medically fragile and who have special health care needs. Beginning November 1, 2012, the Authority may enroll these children in CCOs on a case-by-case basis; children not enrolled in a CCO shall continue to receive services on a FFS basis.

(b) Women who are in their third trimester of pregnancy when first determined eligible for OHP or at re-determination may qualify as identified below to receive OHP benefits on a Fee-for-Service (FFS) basis until 60 days after the birth of her child. After the 60 day period the OHP member must enroll in a CCO. In order to qualify for the FFS third trimester exemption the member must:

(A) Not have been enrolled with a service area CCO, FCHP or PCO during the three months preceding re-determination,

(B) Have an established relationship with a licensed qualified practitioner who is not a participating provider with the service area CCO, FCHP or PCO and wishes to continue obtaining maternity services from the non-participating provider on a FFS basis, and

(C) Make a request to change to FFS prior to the date of the delivery if enrolled with a CCO, FCHP or PCO.

(c) From August 1, 2012 until November 1, 2012, clients receiving health care services through the Breast and Cervical Cancer Program are exempt. Beginning November 1, 2012, enrollment is required;

(d) Existing clients who had organ transplants are exempt until the Authority enrolls them in a CCO on a case-by-case basis; and

(e) From August 1, 2012, until November 1, 2012, clients with end-stage renal disease. Beginning November 1, 2012, enrollment is required.

(17) The following clients who are exempt from CCO enrollment and who receive services on a fee-for-service basis may enroll in a CCO:

(a) Clients who are eligible for both Medicare and Medicaid;

(b) Clients who are American Indian and Alaskan Native beneficiaries;

(18) The Authority may exempt clients or temporarily exempt clients for other just causes as determined by the Authority through medical review. The Authority may set an exemption period on a case-by-case basis. Other just causes include the considerations:

(a) Enrollment would pose a serious health risk; and

(b) The Authority finds no reasonable alternatives.

(19) The following pertains to the effective date of the enrollment. If the enrollment occurs:

(a) On or before Wednesday, the date of enrollment shall be the following Monday; or

(b) After Wednesday, the date of enrollment shall be one week from the following Monday.

(20) Coordinated care services shall begin on the first day of enrollment with the CCO except for:

(a) A newborn's date of birth when the mother was a member of a CCO at the time of birth;

(b) For members who are re-enrolled within 30 calendar days of disenrollment, the date of enrollment shall be the date specified by the Authority that may be retroactive to the date of disenrollment;

(c) For adopted children or children placed in an adoptive placement, the date of enrollment shall be the date specified by the Authority.

Stat. Auth.: ORS 414.042, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 62-2012(Temp), f. 12-27-12, cert. ef. 1-1-13 thru 6-29-13; DMAP 4-2013(Temp), f. & cert. ef. 2-7-13 thru 6-29-13; DMAP 33-2013, f. & cert. ef. 6-27-13; DMAP 38-2013(Temp), f. 7-8-13, cert. ef. 7-9-13 thru 1-5-14

410-141-3080
Disenrollment from Coordinated Care Organizations

This rule applies to DCO's and non-integrated CCO's. A non-integrated CCO is a CCO that has not integrated dental services.

(1) At the time of recertification, a member may disenroll from a CCO or DCO in a service area and enroll in another CCO or DCO in that service area. The primary person in the household shall make this decision on behalf of all household members.

(2) A member who moves from one service area to another service area shall disenroll from the CCO or DCO in the previous service area and enroll with a CCO or DCO in the new service area. The member must change their address with the Authority or Department within ten days of moving.

(3) A member who previously had an exemption from managed care physical health but is enrolled in a MHO or DCO may disenroll from the MHO or DCO to enroll into an integrated CCO in their service area.

(4) A member who voluntarily enrolls in a CCO or DCO per OAR 410-141-3060(19) may disenroll from their CCOs or DCO's at any time and receive health care services on a fee-for service basis or enroll in another CCO or DCO in their service area. This only applies to:

(a) Members who are eligible for both Medicare and Medicaid and

(b) Members who are American Indian and Alaskan Native beneficiaries;

(5) Notwithstanding other sections of this rule, members may request disenrollment for just cause at any time pursuant to state law or CFR 438.56. This includes:

(a) The CCO or DCO does not cover the service the member seeks, because of moral or religious objections;

(b) The member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; or

(c) The member is experiencing poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs.

(6) The Authority may approve the disenrollment after medical review using the following just cause considerations:

(a) Required enrollment would pose a serious health risk; and

(b) The Authority finds no reasonable alternatives.

(7) The following applies to time lines for clients to change their CCO or DCO assignment:

(a) Newly eligible clients may change their CCO or DCO assignment within 90 days of their application for health services;

(b) Existing members may change their CCO or DCO assignment within 30 days of the Authority's automatic assignment in a CCO or DCO; or

(c) Members may change their CCO or DCO assignment upon eligibility redetermination.

(d) Members may change enrollment in their CCO or DCO once during each enrollment period.

(8) Pursuant to CFR 438.56, the CCO or DCO shall not request and the Authority shall not approve disenrollment of a member due to:

(a) A physical or behavioral disability or condition;

(b) An adverse change in the member's health;

(c) The member's utilization of services, either excessive or lacking;

(d) The member's decisions regarding medical or dental care with which the CCO or DCO disagrees;

(e) The member's behavior is uncooperative or disruptive, including but not limited to threats or acts of physical violence, resulting from the member's special needs, except when continued enrollment in the CCO or DCO seriously impairs the CCO's or DCO's ability to furnish services to this particular member or other members.

(9) A CCO or DCO may request the Authority to disenroll a member if the CCO or DCO determines:

(a) Except as provided in OAR 410-141-3050, the member has major medical coverage, including employer sponsored insurance (ESI);

(b) The CCO or DCO determines:

(A) The member has moved to a service area the CCO or DCO does not serve;

(B) The member is out of the CCO's or DCO's area for three months without making arrangements with the CCO or DCO;

(C) The member did not initiate enrollment in the CCO or DCO serving the member's area; and

(D) The member is not in temporary placement or receiving out-of-area services.

(c) The member is in a state psychiatric institution;

(d) The CCO or DCO has verifiable information that the member has moved to another Medicaid jurisdiction; or

(e) The member is deceased.

(10) Before requesting disenrollment under the exception in section (7)(e) of this rule, a CCO or DCO must take meaningful steps to address the member's behavior, including but not limited to:

(a) Contacting the member either orally or in writing to explain and attempt to resolve the issue. The CCO or DCO must document all oral conversations in writing and send a written summary to the member. This contact may include communication from advocates, including peer wellness specialists, where appropriate, personal health navigators and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services;

(b) Developing and implementing a care plan in coordination with the member and the member's care team that details the problem and how the CCO or DCO shall address it;

(c) Reasonably modifying practices and procedures as appropriate to accommodate the member's circumstances;

(d) Assessing the member's behavior to determine if it results from the member's special needs or a disability;

(e) Providing education, counseling and other interventions to resolve the issue; and

(f) Submitting a complete summary to the Authority if the CCO or DCO requests disenrollment.

(11) The Authority may disenroll members of CCOs or DCOs for the reasons specified in section (8) without receiving a disenrollment request from a CCO or DCO.

(12) The CCO or DCO shall request the Authority to suspend a member's enrollment when the inmate is incarcerated in a State or Federal prison, a jail, detention facility or other penal institution for no longer than 12 months. The CCO or DCO shall request that the Authority disenroll a member when the inmate is incarcerated in a State or Federal prison, jail, detention facility or other institution for longer than 12 months. This does not include members on probation, house arrest, living voluntarily in a facility after adjudication of their case, infants living with inmates or inmates admitted for inpatient hospitalization. The CCO or DCO is responsible for identifying the members and providing sufficient proof of incarceration to the Authority for review of the request for suspension of enrollment or disenrollment. CCOs shall pay for inpatient services only during the time a member is an inmate and enrollment is otherwise suspended.

(13) Unless otherwise specified in these rules or in the Authority notification of disenrollment to the CCO or DCO, all disenrollments are effective at the end of the month the Authority approves the disenrollment, with the following exceptions;

(a) The Authority may specify a retroactive disenrollment effective date if the member has:

(A) Third party coverage including employee-sponsored insurance. The effective date shall be the date the coverage begins;

(B) Enrolls in a program for all-inclusive care for the elderly (PACE). The effective date shall be the day before PACE enrollment;

(C) Is admitted to the State Hospital. The effective date shall be the day before hospital admission; or

(D) Becomes deceased. The effective date shall be the date of death.

(b) The Authority may retroactively disenroll or suspend enrollment if the member is incarcerated pursuant to section (11) of this rule. The effective date shall be the date of the notice of incarceration or the day before incarceration, whichever is earlier.

(c) The Authority shall specify a disenrollment effective date if the member moves out of the CCO's or DCO's service area. The Authority shall recoup the balance of that month's capitation payment from the CCO or DCO;

(d) The Authority may specify the disenrollment effective date if the member is no longer eligible for OHP;

(14) The Authority shall inform the members of a disenrollment decision in writing, including the right to request a contested case hearing to dispute the Authority's disenrollment if the Authority disenrolled the member for cause that the member did not request. If the member requests a hearing, the disenrollment shall remain in effect pending outcome of the contested case hearing.

(15) For purposes of a member's right to a contested case hearing, "disenrollment" does not include the Authority's:

(a) Transfer of a member from a PHP to a CCO or DCO;

(b) Transfer of a member from a CCO or DCO to another CCO or DCO; or

(c) Automatic enrollment of a member in a CCO or DCO.

(16) The Authority may approve the transfer of 500 or more members from one CCO or DCO to another CCO or DCO if:

(a) The members' provider has contracted with the receiving CCO or DCO and has stopped accepting patients from or has terminated providing services to members in the transferring CCO or DCO; and

(b) Members are offered the choice of remaining enrolled in the transferring CCO or DCO.

(17) Members may not be transferred under section (15) until the Authority has evaluated the receiving CCO or DCO and determined that the CCO or DCO meets criteria established by the Authority by rule, including but not limited to ensuring that the CCO or DCO maintains a network of providers sufficient in numbers and areas of practice and geographically distributed in a manner to ensure that the health services provided under the contract are reasonably accessible to members.

(18) The Authority shall provide notice of a transfer under section (15) to members that will be affected by the transfer at least 90 days before the scheduled date of the transfer.

(19) Except as otherwise allowed by rule, a member may transfer from one CCO or DCO to another CCO or DCO no more than once during each enrollment period.

Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635 & 414.651

Stats. Implemented: ORS 414.610 - 414.685

Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 47-2012(Temp), f. & cert. ef. 10-16-12 thru 4-13-13; DMAP 55-2012(Temp), f. & cert. ef. 11-15-12 thru 4-13-13; Administrative correction 4-22-13; DMAP 19-2013, f. & cert. ef. 4-23-13; DMAP 25-2013, f. & cert. ef. 6-11-13; DMAP 38-2013(Temp), f. 7-8-13, cert. ef. 7-9-13 thru 1-5-14

410-141-3220

Accessibility

(1) Consistent with the community health assessment and health improvement plan, CCOs must assure that members have access to high quality care. The CCO shall accomplish this developing a provider network that demonstrates communication, collaboration, and shared decision making with the various providers and care settings. The CCO shall develop and implement the assessment and plan over time that meets access-to-care standards, and allows for appropriate choice for members. The goal shall be that services and supports should be geographically as close as possible to where members reside and, to the extent necessary, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations.

(2) CCOs shall ensure access to integrated and coordinated care as outlined in OAR 410-141-3160, which includes access to a primary care provider or primary care team that is responsible for coordination of care and transitions.

(3) In developing its access standards, the CCO should anticipate access needs, so that the members receive the right care at the right time and place, using a patient-centered approach. The CCO provider network shall support members, especially those with behavioral health issues, in the most appropriate and independent setting, including in their own home or independent supported living.

(4) CCOs shall have policies and procedures which ensure that for 90% of their members in each service area, routine travel time or distance to the location of the PCPCH or PCP does not exceed the community standard for accessing health care participating providers. The travel time or distance to PCPCHs or PCPs shall not exceed the following, unless otherwise approved by the Authority:

(a) In urban areas — 30 miles, 30 minutes or the community standard, whichever is greater;

(b) In rural areas — 60 miles, 60 minutes or the community standard, whichever is greater.

(5) CCOs shall have an access plan that establishes standards for access, outlines how capacity is determined and establishes procedures for monthly monitoring of capacity and access, and for improving access and managing risk in times of reduced participating provider capacity. The access plan shall also identify populations in need of interpreter services and populations in need of accommodation under the Americans with Disabilities Act.

(6) CCOs shall make the services it provides including: primary care, specialists, pharmacy, hospital, vision, ancillary, and behavioral health services, as accessible to members for timeliness, amount, duration, and scope as those services are to other members within the same service area. If the CCO is unable to provide those services locally, it must so demonstrate to the Authority and provide reasonable alternatives for members to access care that must be approved by the Authority. CCOs shall have a monitoring system that shall demonstrate to the Authority that the CCO has surveyed and monitored for equal access of members to referral providers of pharmacy, hospital, vision, ancillary, and behavioral health services:

(a) CCOs shall ensure that PCPs screen all eligible members for behavioral health issues to promote prevention, early detection, intervention and referral to treatment, especially at initial contact or physical exam or at initial prenatal examination, when a member shows evidence of behavioral health issues or when a member over utilizes services;

(b) CCOs must use a universal screening process that assesses members for critical risk factors that trigger intensive care coordination for high-needs members.

(7) CCOs shall have policies and procedures and a monitoring system to ensure that members who are aged, blind, or disabled, or who have complex or high health care needs, multiple chronic conditions, behavioral health issues or who are children receiving Department or OYA services have access to primary care, dental care (when the CCO or DCO is responsible for dental care), mental health providers and referral, and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services.

(8) CCOs shall have policies and procedures that ensure scheduling and rescheduling of member appointments are appropriate to the reasons for, and urgency of, the visit. The member shall be seen, treated, or referred as within the following timeframes:

(a) Emergency care — Immediately or referred to an emergency department depending on the member's condition;

(b) Urgent care — Within 72 hours or as indicated in initial screening, in accordance with OAR 410-141-0140;

(c) Well care — Within 4 weeks or within the community standard;

(d) Emergency dental care (when dental care is provided by the CCO or DCO) — Seen or treated within 24-hours;

(e) Urgent dental care (when dental care is provided by the CCO or DCO) — Within one to two weeks or as indicated in the initial screening in accordance with OAR 410-123-1060; and

(f) Routine dental care (when dental care is provided by the CCO or DCO) — Seen for routine care within an average of eight weeks and within 12 weeks or the community standard, whichever is less, unless there is a documented special clinical reason which would make access longer than 12 weeks appropriate;

(g) Non-Urgent behavioral health treatment — Seen for an intake assessment within 2 weeks from date of request.

(9) CCOs shall develop policies and procedures for communicating with, and providing care to members who have difficulty communicating due to a medical condition or who are living in a household where there is no adult available to communicate in English or here there is no telephone:

(a) The policies and procedures shall provide certified or qualified interpreter services by phone, in person, in CCO administrative offices, especially those of member services and complaint and grievance representatives and in emergency rooms of contracted hospitals;

(b) CCOs shall ensure the provision of certified or qualified interpreter services for covered coordinated care services including medical, behavioral health or dental care (when the CCO or DCO is responsible for dental care) visits, and home health visits, to interpret for members with hearing impairment or in the primary language of non-English speaking members. All interpreters shall be linguistically appropriate and be capable of communicating in English and the members' primary language and able to translate clinical information effectively. Interpreter services shall be sufficient for the provider to understand the member's complaint; to make a diagnosis; respond to member's questions and concerns; and to communicate instructions to the member;

(c) CCOs shall ensure the provision of coordinated care services which are culturally appropriate, i.e., demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the members' care;

(d) CCOs shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990 in providing access to covered coordinated care services for all members and shall arrange for services to be provided by non- participating referral providers when necessary;

(e) CCOs shall have a plan for ensuring compliance with these requirements and shall monitor for compliance.

Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 38-2013(Temp), f. 7-8-13, cert. ef. 7-9-13 thru 1-5-14

410-141-3420
Billing and Payment

(1) Subject to other applicable Division billing rules, providers must submit all billings for CCO members following the timeframes in (a) and (b) below:

(a) Submit billings within 12 months of the date of service in the following cases:

(A) Member pregnancy;

(B) Eligibility issues such as retroactive deletions or retroactive enrollments;

(C) Medicare is the primary payer, except where the CCO is responsible for the Medicare reimbursement;

(D) Other cases that could have delayed the initial billing to the CCO (which does not include failure of provider to certify the member's eligibility); or

(E) Third Party Liability (TPL). Pursuant to 42 CFR 36.61, subpart G: Indian Health Services and the amended Public Law 93-638 under the Memorandum of Agreement that Indian Health Service and 638 Tribal Facilities are the payer of last resort and is not considered an alternative liability or TPL.

(b) Submit bills within four months of the date of service for all other cases.

(2) Providers must be enrolled with the Authority's Division of Medical Assistance Programs to be eligible for fee-for-service (FFS) payments. Mental health providers, except Federally Qualified Health Centers (FQHC), must be approved by the Local Mental Health Authority (LMHA) and the Authority's Addictions and Mental Health (AMH) Division before enrollment with the Authority or to be eligible for CCO payment for services. Providers may be retroactively enrolled, in accordance with OAR 410-120-1260 (Provider Enrollment).

(3) Providers, including mental health providers, must be enrolled with the Authority as a Medicaid provider or an encounter-only provider prior to submission of encounter data to ensure the encounter is accepted.

(4) Providers shall verify, before providing services, that the member is eligible for coordinated care services on the date of service. Providers shall use the Authority tools and the CCO's tools, as applicable, to determine if the service to be provided is covered under the member's Oregon Health Plan Benefit Package of covered services. Providers shall also identify the party responsible for covering the intended service and seek preauthorizations from the appropriate payer before providing services. For non-covered services, providers shall follow requirements in OAR 141-120-1280.

(5) CCOs shall pay for all covered coordinated care services. These services must be billed directly to the CCO, unless the CCO or the Authority specifies otherwise. CCOs may require providers to obtain preauthorization to deliver certain coordinated care services.

(6) Payment by the CCO to participating providers for coordinated care services is a matter between the CCO and the participating provider, except as follows:

(a) CCOs shall have procedures for processing pre-authorization requests received from any provider. The procedures shall specify time frames for:

(A) Date stamping pre-authorization requests when received;

(B) Determining within a specific number of days from receipt whether a pre-authorization request is valid or non-valid;

(C) The specific number of days allowed for follow up on pended preauthorization requests to obtain additional information;

(D) The specific number of days following receipt of the additional information that a redetermination must be made;

(E) Providing services after office hours and on weekends that require preauthorization;

(F) Sending notice of the decision with appeal rights to the member when the determination is a denial of the requested service as specified in OAR 410-141-3263.

(b) CCOs shall make a determination on at least 95% of valid preauthorization requests, within two working days of receipt of a preauthorization or reauthorization request related to urgent services; Substance Use Disorder services; or care required while in a skilled nursing facility. Preauthorization for prescription drugs must be completed and the pharmacy notified within 24 hours. If a preauthorization for a prescription cannot be completed within the 24 hours, the CCO must provide for the dispensing of at least a 72-hour supply if there is an immediate medical need for the drug. CCOs shall notify providers of the determination within 2 working days of receipt of the request;

(c) For expedited prior authorization requests in which the provider indicates, or the CCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function:

(A) The CCO must make an expedited authorization decision and provide notice as expeditiously as the member's health or mental health condition requires and no later than three working days after receipt of the request for service;

(B) The CCO may extend the three working day time period no more than 14 calendar days if the member requests an extension, or if the CCO justifies to the Authority a need for additional information and how the extension is in the member's best interest.

(d) For all other preauthorization requests, CCOs shall notify providers of an approval, a denial or the need for further information within 14 calendar days of receipt of the request. CCOs must make reasonable efforts to obtain the necessary information during the 14-day period. However, the CCO may use an additional 14 days to obtain follow-up information, if the CCO justifies (to the Authority upon request) the need for additional information and how the delay is in the interest of the member. The CCO shall make a determination as the member's health or mental health condition requires, but no later than the expiration of the extension.

(7) CCOs shall have written procedures for processing payment claims submitted from any source. The procedures shall specify time frames for:

(a) Date stamping claims when received;

(b) Determining within a specific number of days from receipt whether a claim is valid or non-valid;

(c) The specific number of days allowed for follow up of pended claims to obtain additional information;

(d) The specific number of days following receipt of additional information that a determination must be made; and

(e) Sending notice of the decision with appeal rights to the member when the determination is made to deny the claim;

(f) CCOs shall pay or deny at least 90% of valid claims within 45 calendar days of receipt and at least 99% of valid claims within 60 calendars days of receipt. CCOs shall make an initial determination on 99% of all claims submitted within 60 calendar days of receipt;

(g) CCOs shall provide written notification of CCO determinations when the determinations result in a denial of payment for services, for which the member may be financially responsible. The CCO shall provide the notice to the member and the treating provider within 14 calendar days of the final determination. The notice to the member shall be a Division or AMH approved notice format and shall include information on the CCOs

internal appeals process, and Hearing Rights (DMAP 3030) shall be attached. The notice to the provider shall include the reason for the denial;

(h) CCOs may not require providers to delay billing to the CCO;

(i) CCOs may not require Medicare be billed as the primary insurer for services or items not covered by Medicare, or require non-Medicare approved providers to bill Medicare;

(j) CCOs may not deny payment of valid claims when the potential TPR is based only on a diagnosis, and no potential TPR has been documented in the member's clinical record;

(k) CCOs may not delay or deny payments because a co-payment was not collected at the time of service.

(8) CCOs shall pay for Medicare coinsurances and deductibles up to the Medicare or CCOs allowable for covered services the member receives within the CCO, for authorized referral care, and urgent care services or emergency services the member receives from non-participating providers. CCOs may not pay for Medicare coinsurances and deductibles for non-urgent or non-emergent care members receive from non-participating providers.

(9) CCOs shall pay transportation, meals and lodging costs for the member and any required attendant for out-of-state services that the CCO has arranged and authorized when those services are not available within the state, unless otherwise approved by the Authority.

(10) CCOs shall pay for covered services provided by a non-participating provider which was not preauthorized if the following conditions exist:

(a) It can be verified that the participating provider ordered or directed the covered services to be delivered by a non-participating provider; and

(b) The covered service was delivered in good faith without the pre-authorization; and

(c) It was a covered service that would have been pre-authorized with a participating provider if the CCO's referral procedures had been followed;

(d) The CCO shall pay non-participating providers (providers enrolled with the Authority that do not have a contract with the CCO) for covered services that are subject to reimbursement from the CCO, in the amount specified in OAR 410-120-1295. This rule does not apply to providers that are Type A or Type B hospitals;

(e) CCOs shall reimburse hospitals for services provided on or after January 1, 2012 using Medicare Severity DRG for inpatient services and Ambulatory Payment Classification (APC) for outpatient services or other alternative payment methods which incorporate the most recent Medicare payment methodologies for both inpatient and outpatient services established by CMS for hospital services; and alternative payment methodologies, including but not limited to pay-for-performance, bundled payments and capitation. An alternative payment methodology does not include reimbursement payment based on percentage of billed charges. This requirement does not apply to Type A or Type B hospitals as referenced in ORS 442.470. CCO shall attest annually to the Authority, in a manner to be prescribed, to CCO's compliance with these requirements.

(11) Members may receive certain services on a Fee for Service (FFS) basis:

(a) Certain services must be authorized by the CCO or the Community Mental Health Program (CMHP) for some mental health services, even though the services are then paid by the Authority on a FFS basis. Before providing services, providers must verify a member's eligibility using the web portal or AVR;

(b) Services authorized by the CCO or CMHP are subject to the rules and limitations of the appropriate Authority administrative rules and supplemental information, including rates and billing instructions;

(c) Providers shall bill the Authority directly for FFS services in accordance with billing instructions contained in the Authority administrative rules and supplemental information;

(d) The Authority shall pay at the Medicaid FFS rate in effect on the date the service is provided subject to the rules and limitations described in the relevant rules, contracts, billing instructions;

(e) The Authority may not pay a provider for provision of services for which a CCO has received a CCO payment unless otherwise provided for in rule;

(f) When an item or service is included in the rate paid to a medical institution, a residential facility or foster home, provision of that item or service is not the responsibility of the Authority or a CCO except as provided in Authority administrative rules and supplemental information (e.g., coordinated care services that are not included in the nursing facility all-inclusive rate);

(g) CCOs that contract with FQHCs and RHCs shall negotiate a rate of reimbursement that is not less than the level and amount of payment which the CCO would pay for the same service furnished by a provider, who is not an FQHC nor RHC, consistent with the requirements of BBA 4712(b)(2).

(12) Coverage of services through the Oregon Health Plan Benefit Package of covered services is limited by OAR 410-141-0500, excluded services and limitations for OHP clients.

(13) Billing and coverage of Dental Services is governed by OAR 410 division 123.

Stat. Auth.: ORS 414.032, 414.615, 414.625, 414.635 & 414.651
Stats. Implemented: ORS 414.610 - 414.685
Hist.: DMAP 16-2012(Temp), f. & cert. ef. 3-26-12 thru 9-21-12; DMAP 37-2012, f. & cert. ef. 8-1-12; DMAP 38-2013(Temp), f. 7-8-13, cert. ef. 7-9-13 thru 1-5-14

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Oregon Health Authority, Oregon Educators Benefit Board
Chapter 111

Rule Caption: Amendments to this rule align rule language with current OEBB processes
Adm. Order No.: OEBB 5-2013
Filed with Sec. of State: 7-12-2013
Certified to be Effective: 7-12-13
Notice Publication Date: 6-1-2013
Rules Amended: 111-065-0010, 111-065-0015, 111-065-0025, 111-065-0030
Rules Repealed: 111-065-0010(T), 111-065-0015(T), 111-065-0025(T), 111-065-0030(T)
Subject: Amendments to OAR 111-065-0010, 111-065-0015, 111-065-0025 and 111-065-0030 align rule language with current OEBB processes related to payment information for early retirees who self-pay their insurance premiums directly to OEBB.
Rules Coordinator: April Kelly—(503) 378-6588

111-065-0010
OEBB Early Retiree Invoicing

(1) OEBB will enroll the Early Retiree after OEBB has received the enrollment form and one of the following is completed:

(a) The required ACH Authorization for a recurring Direct Debit Payment is received from the early retiree to initiate the setup of automated payments via ACH; or

(b) An Exception Request Form is received from the early retiree and reviewed and approved by OEBB.

(2) OEBB will send payment invoices to early retirees that will provide notification of the amount and payment due date or the date the automatic checking deduction will occur. OEBB will send invoices on or around the 15th of the month with payment due on the 2nd business day of the following month.

(3) Advance payments may be made only within the same Plan Year. However, any remaining balances will be carried into the next Plan Year.

Stats. Auth.: 243.860 - 243.886
Stats. Implemented: ORS 243.864(1)(a)
Hist.: OEBB 6-2012(Temp), f. & cert. ef. 4-20-12 thru 10-16-12; OEBB 11 2012, f. & cert. ef. 10-9-12; OEBB 2-2013(Temp) f. & cert. ef. 4-22-13 thru 10-18-13; OEBB 5-2013, f. & cert. ef. 7-12-13

111-065-0015
Early Retiree Payment Methods and Due Dates

(1) Premium payments will be made through Direct Debit via ACH on the 2nd business day of the month unless otherwise prior authorized by designated OEBB staff.

(2) As necessary, or upon written request of a participating Early Retiree, OEBB staff will review and determine if an alternative withdrawal date is warranted to avoid future payments being returned for Non-sufficient Funds (NSF) on a recurring basis.

(3) OEBB will accept payment from early retirees by methods other than Direct Debit when specific exceptions apply:

(a) The individual does not have an account with a financial institution within the United States;

(b) The individual's special circumstances, which OEBB will review on a case by case basis.

(4) A request for exception must be made in writing and include the reason why or special circumstance that would not allow the member to submit payment via Direct Debit.

(5) OEBB will review the request for exception, determine whether to allow or deny the exception, and notify the requesting party of its decision within 21 days of receipt of the request.

(6) Notwithstanding OAR 111-065-0010, all premium payments must be received on or before the 2nd business day of the month for the current month's health care coverage. All payments will be subject to this due date.

(7) If the Early Retiree has a checking account, but submits a written letter declining to use the Direct Debit payment method, a $35.00 processing fee shall be applied to the Early Retiree's monthly premium.

Stats. Auth.: 243.860 - 243.886
Stats. Implemented: ORS 243.864(1)(a)
Hist.: OEBB 6-2012(Temp), f. & cert. ef. 4-20-12 thru 10-16-12; OEBB 11 2012, f. & cert. ef. 10-9-12; OEBB 2-2013(Temp) f. & cert. ef. 4-22-13 thru 10-18-13; OEBB 5-2013, f. & cert. ef. 7-12-13

111-065-0025
Early Retiree Underpayments

(1) Premiums must be paid in full on or before the 2nd business day of the month, unless otherwise pre-approved by OEBB under OAR 111-065-0015(2).

(2)(a) Early retirees will be notified if their coverage was terminated due to the premium not being paid in full on the specified due date, including payments returned by the bank for Non-Sufficient Funds (NSF), closed bank accounts, and frozen accounts.

(b) A check or ACH transaction that is returned for NSF, closed bank account, or frozen account is considered non-payment of premiums.

Stats. Auth.: 243.860 - 243.886
Stats. Implemented: ORS 243.864(1)(a)
Hist.: OEBB 6-2012(Temp), f. & cert. ef. 4-20-12 thru 10-16-12; OEBB 11 2012, f. & cert. ef. 10-9-12; OEBB 2-2013(Temp) f. & cert. ef. 4-22-13 thru 10-18-13; OEBB 5-2013, f. & cert. ef. 7-12-13

111-065-0030
Termination

(1) OEBB shall not be responsible for any unpaid portion of premiums for coverage and will terminate the early retiree and dependent coverage for non-payment or underpayment of premiums due.

(2) OEBB coverage will be terminated under the following circumstances:

(a) Premiums are not paid in full by the due date. If the payment is not received in full on the 2nd business day of the month unless otherwise preapproved by OEBB under OAR 111-065-0015(2), the early retiree's coverage will be terminated on the last day of the month in which a full premium payment was received; or

(b) As referenced in 111-050-0015.

Stats. Auth.: 243.860 - 243.886
Stats. Implemented: ORS 243.864(1)(a)
Hist.: OEBB 6-2012(Temp), f. & cert. ef. 4-20-12 thru 10-16-12; OEBB 11 2012, f. & cert. ef. 10-9-12; OEBB 2-2013(Temp) f. & cert. ef. 4-22-13 thru 10-18-13; OEBB 5-2013, f. & cert. ef. 7-12-13

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Rule Caption: Amendments made to this rule to update and clarify definitions used by OEBB
Adm. Order No.: OEBB 6-2013
Filed with Sec. of State: 7-12-2013
Certified to be Effective: 7-12-13
Notice Publication Date: 6-1-2013
Rules Amended: 111-010-0015
Subject: Amendments made to this rule are to update and clarify definitions used by OEBB.
Rules Coordinator: April Kelly—(503) 378-6588

111-010-0015
Definitions

Unless the context indicates otherwise, as used in OEBB administrative rules, the following definitions will apply:

(1) "Actuarial value" means the expected financial value for the average member of a particular benefit plan.

(2) "Adverse Benefit Determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part), for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on but not limited to:

(a) A determination of a member's eligibility to participate in the plan;

(b) A determination that the benefit is not a covered benefit; or

(c) A rescission of coverage, whether or not, in connection with rescission, there is an adverse effect on any particular benefit.

(3) "Affidavit of Domestic Partnership" means a document that attests the eligible employee and one other eligible individual meet the criteria in section (15)(b).

(4) "Benefit plan" includes, but is not limited to, insurance or other benefits including:

(a) Medical (including non-integrated health reimbursement arrangements (HRAs));

(b) Dental;

(c) Vision;

(d) Life, disability and accidental death;

(e) Long term care;

(f) Employee Assistance Program Plans;

(g) Supplemental medical, dental and vision coverages (including Integrated General Purpose and Integrated Post-Deductible health reimbursement arrangements (HRAs); and Limited Purpose, Post-Separation/Retiree, and Premium Only health reimbursement arrangements (HRAs));

(h) Any other remedial care recognized by state law, and related services and supplies;

(i) Comparable benefits for employees who rely on spiritual means of healing; and

(j) Self-insurance programs managed by the Board.

(5) "Benefits" means goods and services provided under Benefit Plans.

(6) "Board" means the ten-member board established in the Department of Administrative Services as the Oregon Educators Benefit Board under chapter 00007, Oregon Laws 2007.

(7) "Child" means and includes the following:

(a) An eligible employee's, spouse's, or domestic partner's biological son or daughter; adopted child; child placed for adoption; or legally placed child, who is 25 or younger on the first day of the month. An eligible employee must provide the required custody or legal documents to their Educational Entity showing proof of adoption, legal guardianship or other court order if enrolling a child for whom the employee, spouse, or domestic partner is not the biological parent. Grandchildren are only eligible when the eligible employee is the legal guardian or adoptive parent of the grandchild.

(b) A person who is incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability. There is no age limit for a dependent child who is incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability. When the dependent child is 26 years of age or older all the following requirements must be met:

(A) The disability must have existed before attaining age 26.

(B) The employee must provide evidence to the Educational Entity or OEBB that (1) the person had health plan coverage, group or individual, prior to attaining age 26, and (2) health plan coverage continued without a gap until the OEBB health plan effective date.

(C) The person's attending physician must submit documentation of the disability to the eligible employee's OEBB health insurance plan for review and approval. If the person receives health plan approval, the health plan may review the person's health status at any time to determine continued OEBB coverage eligibility.

(D) The person must not have terminated from OEBB health plan coverage after attaining the age of 26.

(c) Eligibility for coverage under this rule includes people who may not be dependents under federal or state tax law and may require an Educational Entity to adjust an Eligible Employee's income based on the imputed value of the benefit.

(8) "Comparable cost (Medical, Dental and Vision)" means that the total cost to a district for enrollment in OEBB plans comparable in design to the district's plan(s) do not exceed the total cost to a district for enrollment in the district's plan(s) using the rate(s) in effect or proposed for the benefit plan year.

(9) "Comparable cost (Basic and Optional Life Insurance, Accidental Death & Dismemberment, and Short and Long Term Disability)" means that the premium rates of an OEBB plan design option do not exceed the average, aggregate premium rates of a district's pre-OEBB plan design in effect the year prior to implementation.

(10) "Comparable plan design (Medical, Dental and Vision)" means that the actuarial values of two plan designs are within 2.5 percent higher or lower of each other.

(11) "Comparable plan design (Basic and Optional Life Insurance and Accidental Death & Dismemberment)" means that 90 percent of district employees can obtain a maximum benefit through an OEBB plan design

that is within $2,500 of the maximum benefit obtained through a pre-OEBB plan design in effect the year prior to implementation.

(12) "Comparable plan design (Short and Long Term Disability)" means 90 percent of the district employees can obtain the same elimination period, percentage of covered compensation, definition of covered compensation, coverage period duration, and maximum payment per benefit period through an OEBB plan design as through a pre-OEBB plan design in effect the year prior to implementation.

(13) "Dependent" means and includes the eligible employee's spouse or domestic partner, or child as defined by OAR 111-010-0010(7), unless otherwise defined in another OEBB rule.

(14) "Documented district policies" means Educational Entities' policies and practices that apply to an employee group and are submitted to the Oregon Educators Benefit Board during the plan selection process. Educational Entities' policies and practices must be identified and submitted with the applicable employee group plan selections.

(15) "Eligible Domestic partner," unless otherwise defined by a collective bargaining agreement or documented district policy in effect on January 31, 2008, means and includes the following:

(a) An unmarried individual of the same sex who has entered into a "Declaration of Domestic Partnership" with the eligible employee that is recognized under Oregon law; or

(b) An unmarried individual of the same or opposite sex who has entered into a partnership that meets the following criteria:

(A) Both are at least 18 years of age;

(B) Are responsible for each other's welfare and are each other's sole domestic partners;

(C) Are not married to anyone and have not had a spouse or another domestic partner within the prior six months. If previously married, the six-month period starts on the final date of divorce;

(D) Share a close personal relationship and are not related by blood closer than would bar marriage in the State of Oregon;

(E) Have jointly shared the same regular and permanent residence for at least six months immediately preceding the date the Affidavit of Domestic Partnership is signed and submitted to the Educational Entity; and

(F) Are jointly financially responsible for basic living expenses defined as the cost of food, shelter and any other expenses of maintaining a household. Financial information must be provided if requested.

(G) The eligible employee and domestic partner must jointly complete and submit to the Educational Entity an Affidavit of Domestic Partnership form, within five business days of the electronic enrollment date or the date the Educational Entity received the enrollment/change form. If the affidavit is not received, coverage will terminate for the domestic partner retroactive to the effective date.

(c) The Eligible Employee must notify the Educational Entity within 31 days of meeting all criteria as defined in 111-010-0015 (15)(b) or obtaining the "Declaration of Domestic Partnership" which is recognized under Oregon law.

(d) Educational Entities' must calculate and apply applicable imputed value tax for domestic partners covered under OEBB benefit plans.

(16) "Educational Entity" means public school districts (K–12), education service districts (ESDs), community colleges and public charter schools participating in OEBB.

(17) "Eligible employee" means and includes an employee of an Educational Entity who is actively working or on paid or unpaid leave that is recognized by federal or state law, and:

(a) Is employed in a half time or greater position or is in a job-sharing position; or

(b) Meets the definition of an eligible employee under a separate OEBB rule or under a collective bargaining agreement or documented district policy in effect on January 31, 2008; or

(c) Is an employee of a community college who is covered under a collectively bargained contract and has worked a class load of between 25 percent and 49 percent for a minimum period of two years and is expected to continue to work a class load of at least 25 percent. Coverage is limited to medical to include Kaiser Medical Plan 2 (where available), Moda Health Plan E, Moda Health Plan G, or Moda Health Plan H. Moda Health Plan H can only be elected if the eligible employee is eligible for and actively contributing to a Health Savings Account (HSA). The tiered rate structure will apply to all medical plans.

(18) " Eligible Early Retiree" means and includes a previously Eligible Employee who is:

(a) Not Medicare-eligible; or

(b) Under 65 years old; and

(A) Receiving a service or disability retirement allowance or pension under the Public Employees Retirement System (PERS) or under any other retirement or disability benefit plan or system offered by an OEBB participating organization for its employees;

(B) Eligible to receive a service retirement allowance under PERS and has reached earliest retirement age under ORS Chapter 238;

(C) Eligible to receive a pension under ORS 238A.100 to 238A.245 and has reached earliest retirement age as described in ORS 238A.165; or

(D) Eligible to receive a service retirement allowance or pension under another retirement benefit plan or system offered by an OEBB participating organization and has reached earliest retirement age under the plan or system.

(19) "Employee Group" means employees and early retirees of a similar employment type, for example administrative, represented classified, non-represented classified, confidential, represented licensed, or non-represented licensed, within an Educational Entity. If one or more collective bargaining unit exists within an employee group, each unit will be considered a separate employee group.

(20) "Flexible benefit plan" includes plans that allow contributions on a tax-favored basis including health savings accounts.

(21) "Health Reimbursement Arrangement (HRA)" means an account established and funded solely by the employer that can be used to pay for qualified health care expenses for eligible employees and their spouses and federal tax dependents, up to a maximum dollar amount for a coverage period, and any unused portion of the maximum dollar amount at the end of a coverage period is carried forward to increase the maximum reimbursement amount in subsequent coverage periods. This definition should be interpreted to comply with the guidelines established by the IRS for treatment of HRAs on a tax-favored basis in IRS Publication 969 and IRS Notice 2002-45. HRA includes, but is not limited to, the following:

(a) "Integrated General Purpose HRA" is an HRA that allows participants to be reimbursed for all IRS qualified expenses and is available only to eligible employees who are enrolled in an OEBB medical plan as the primary subscriber.

(b) "Integrated Post-Deductible HRA" is an HRA that allows participants to be reimbursed for expenses up to a certain amount, but only after the participants have met the annual deductible on an OEBB medical plan in which the employee participant is enrolled as the primary subscriber.

(c) "Limited Purpose HRA" is an HRA that allows participants to be reimbursed for only standard dental, vision, and orthodontia expenses and does not require the employee participant to be enrolled in an OEBB medical plan as the primary subscriber, or as a dependent.

(d) "Non-integrated HRA" is an HRA that allows participants to be reimbursed for all IRS qualified expenses when the employee participant is not enrolled in an OEBB medical plan as the primary subscriber.

(e) "Post-Separation/Retiree HRA" is an HRA that allows participants to be reimbursed for qualified expenses only after the employee separates/retires and does not require the employee participant to be enrolled in an OEBB medical plan as the primary subscriber, or as a dependent.

(f) "Premium Only HRA" is an HRA that allows participants to be reimbursed only for insurance premiums paid on an after tax basis, where the employee participant has no ability to pay the premium on a pre-tax basis and the HRA does not require the employee participant to be enrolled in an OEBB medical plan as the primary subscriber, or as a dependent.

(22) "Health Savings Account (HSA)" means a tax-exempt trust or custodial account that is set up with a qualified HSA trustee to pay or reimburse certain incurred medical expenses, as defined in 26 U.S.C. § 223(d) and IRS Publication 969.

(23) "High Deductible Health Plan (HDHP)" means a health plan that meets the criteria for a "high deductible health plan" as outlined in 26 U.S.C. § 223(c)(2). Enrollment in an HDHP is one of the requirements that must be met in order to qualify to contribute to a health savings account (HSA).

(24) "Members" means and includes the following:

(a) "Eligible employee" as defined by OAR 111-010-0015(17).

(b) "Child" as defined by OAR 111-010-0015(7).

(c) "Domestic Partner" as defined by OAR 111-010-0015(15).

(d) "Spouse" as defined by OAR 111-010-0015(30).

(25) "Non-subject District" means a community college not yet participating in benefit plans provided by the Oregon Educators Benefit Board, or a charter school whose employees are not considered employees of a school district.

(26) "Oregon Educators Benefit Board or OEBB" means the program created under chapter 00007, Oregon Laws 2007.

(27) "OEBB participating organization" means a Subject District, Non-subject District, or Provisional Non-subject District that participates in benefit plans provided by the Oregon Educators Benefit Board (OEBB).

(28) "Provisional Non-subject District" means a common school district, a union high school district, or an education service district that:

(a) Was self-insured on December 31, 2006;

(b) Had an independent health insurance trust established and functioning on December 31, 2006; or

(c) Can provide comparable plan designs at a comparable cost as defined by sections (8) and (10) of this Rule.

(29) "Qualified Status Change (QSC)" means a change in family or work status that allows limited mid-year changes to benefit plans consistent with the individual event.

(30) "Spouse" means a person of the opposite sex who is a husband or wife. Except as provided in Oregon Constitution Article XV, Section 5a, a relationship recognized as a marriage in another state will be recognized in Oregon even though such a relationship would not be a marriage if the same facts had been relied upon to create a marriage in Oregon. The definition of spouse does not include a former spouse and a former spouse does not qualify as a dependent.

(31) "Subject District" means a common school district, a union high school district, or an education service district that:

(a) Did not self-insure on January 1, 2007;

(b) Did not have a health trust in effect on January 1, 2007; or

(c) Does not provide comparable plan designs at a comparable cost as defined by sections (8) and (10) of this rule.

Stat. Auth.: ORS 243.860 – 243.886
Stats. Implemented: ORS 243.864(1)(a)
Hist.: OEBB 2-2007(Temp), f. & cert. ef. 9-21-07 thru 3-18-08; OEBB 2-2008, f. & cert. ef. 1-4-08; OEBB 10-2008(Temp), f. & cert. ef. 8-13-08 thru 2-6-09; OEBB 1-2009, f. & cert. ef. 1-30-09; OEBB 5-2009(Temp), f. & cert. ef. 3-10-09 thru 9-4-09; OEBB 8-2009, f. & cert. ef. 5-1-09; OEBB 12-2009(Temp), f. & cert. ef. 7-31-09 thru 1-26-10; OEBB 19-2009, f. & cert. ef. 12-17-09; OEBB 7-2010(Temp), f. & cert. ef. 8-3-10 thru 1-29-11; OEBB 11-2010(Temp), f. 9-30-10, cert. ef. 10-1-10 thru 1-29-11; OEBB 1-2011, f. & cert. ef. 2-11-11; OEBB 6-2011(Temp), f. & cert. ef. 2-15-11 thru 8-13-11; OEBB 14-2011, f. & cert. ef. 8-2-11; OEBB 15-2011(Temp), f. & cert. ef. 8-2-11 thru 1-28-12; OEBB 16-2011(Temp), f. 9-30-11, cert. ef. 10-1-11 thru 1-28-12; OEBB 20-2011, f. 10-13-11, cert. ef. 10-14-11; OEBB 22-2011, f. & cert. ef. 12-14-11; OEBB 13-2012, f. & cert. ef. 12-19-12; OEBB 6-2013, f. & cert. ef. 7-12-13

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Rule Caption: Amendments to this rule update plans available, open enrollment period and premium payments
Adm. Order No.: OEBB 7-2013(Temp)
Filed with Sec. of State: 7-12-2013
Certified to be Effective: 7-12-13 thru 1-7-14
Notice Publication Date:
Rules Amended: 111-070-0005, 111-070-0015, 111-070-0050
Subject: Amendments to 111-070-0005 update plans available to this group. Amendments to 111-070-0015 extend the open enrollment timeframe and amendments to 111-070-0050 add a processing fee if the member declines the use of the electronic funds transfer and has a checking account.
Rules Coordinator: April Kelly—(503) 378-6588

111-070-0005
Plan Selections

HB 2557 eligible members will use the tiered rate structure and may elect to enroll in Moda Health Plan E, Moda Health Plan G, or Moda Health Plan H. Moda Health Plan H can only be elected if the HB 2557 member qualifies for and contributes to Health Savings Account (HSA).

Stat. Auth.: ORS 243.860 - 243.886
Stats. Implemented 243.864(1)(a)
Hist.: OEBB 4-2010, f. & cert. ef. 3-15-10; OEBB 7-2013(Temp), f. & cert. ef. 7-12-13 thru 1-7-14

111-070-0015
Enrollment

(1) OEBB will directly provide HB 2557 eligible members notice of their eligibility, the open enrollment schedule and instructions for completing the required enrollment information prior to the beginning of the open enrollment period.

(2) HB 2557 eligible members and eligible dependents may enroll in a medical plan as specified in 111-070-0005 when one of the following occurs:

(a) During the annual open enrollment period (August 15 through September 25);

(A) Required enrollment information may be submitted by the member to the OEBB office prior to the beginning of the open enrollment period;

(B) All required enrollment information must be received from the member by OEBB by close of business on September 25;

(C) Required enrollment information not received from the member on or before the end of the open enrollment period will be considered a declination of coverage for the Plan Year;

(D) Coverage selected will be effective at the beginning of the new Plan Year (October 1) for HB 2557 eligible member and dependent(s) who have submitted the required enrollment information by the submission deadline; or

(b) Following confirmation that an individual not initially identified as eligible for benefits is eligible for benefits:

(A) All required enrollment information must be received from the member by OEBB by close of business on the date specified in the written eligibility notice sent to the HB 2557 eligible member. Failure to meet the due date will be considered a declination of coverage for the Plan Year;

(B) Coverage selected will be effective the first day of the month following eligibility confirmation and receipt of the required enrollment information.

Stat. Auth.: ORS 243.860 - 243.886
Stats. Implemented 243.864(1)(a)
Hist.: OEBB 4-2010, f. & cert. ef. 3-15-10; OEBB 7-2013(Temp), f. & cert. ef. 7-12-13 thru 1-7-14

111-070-0050
Premium Payment

(1) **HB 2557 Eligible Member Payment Methods and Due Dates**:

(a) HB 2557 eligible members will submit payment to OEBB for benefits by electronic funds transfer (EFT).

(b) OEBB may grant an exception from the requirement in section (1) to pay by EFT if the HB 2557 eligible member demonstrates their financial institution cannot accommodate an EFT transfer, or the member does not maintain an account at a financial institution.

(c) Notwithstanding section (2), the electronic transfer of funds will occur on the 25th day of the month prior to the next month's health care coverage. All payments will be subject to this due date.

(2) If the HB 2557 member has a checking account, but submits a written letter declining to use the electronic funds transfer payment method, a $35.00 processing fee shall be applied to the HB 2557 member's monthly premium.

(3) **HB 2557 Eligible Member Invoicing**:

(a) OEBB will enroll a new HB 2557 eligible member after one of the following is completed:

(A) The required ACH payment agreement for electronic transfer of funds is received from the member, processed and set-up with their financial institution; or

(B) The Exception Request Form is received from the member, reviewed and approved;

(b) OEBB will mail payment reminders to HB 2557 eligible members to provide notification of the amount and date the automatic checking deduction will occur.

(c)(A) If the payment is not received in full by the 25th calendar day of the month, the member's coverage will be terminated on the last day of the month in which a full premium payment was received. All premium payments must be paid in full before payment to the carrier will be made.

(B) OEBB shall not be responsible for any unpaid portion of premiums for coverage and will terminate the HB 2557 eligible member and dependent coverage for non-payment or underpayment of premiums due.

(4) **HB 2557 Eligible Member Overpayments**:

(a) OEBB will mail notification of overpayments to the HB 2557 eligible member. This written notice shall inform the member of the amount overpaid and a description of the overpayment.

(b)(A) OEBB will automatically apply any overpayments to the next month's premium due. The member may complete a Request for Reimbursement form if a refund of an overpayment is desired. However, the member may be responsible for processing fees associated with refunds less than $100.

(B) Remaining balances on coverage that has ended will be refunded in full.

(5) **HB 2557 Eligible Member Underpayments**:

(a) Premiums that are not paid in full by the 25th calendar day of the month prior to the coverage effective month will result in the eligible member's and dependent's coverage being terminated at the end of the last month for which premiums were paid in full.

(b)(A) HB 2557 eligible members will be notified if their coverage was terminated due to the premium not being paid in full, including payments returned by the bank for Non-Sufficient Funds (NSF).

(B) A check or ACH transaction that is returned for NSF is considered non-payment of premiums.

(c) Coverage terminated due to non-payment or underpayment cannot be reinstated until a following Plan Year in which a person is deemed a HB 2557 eligible member.

Stat. Auth.: ORS 243.860 - 243.886
Stats. Implemented 243.864(1)(a)
Hist.: OEBB 4-2010, f. & cert. ef. 3-15-10; OEBB 7-2013(Temp), f. & cert. ef. 7-12-13 thru 1-7-14

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Rule Caption: Removing development of benefit plans from rule and updating new plans and plan requirements
Adm. Order No.: OEBB 8-2013(Temp)
Filed with Sec. of State: 7-12-2013
Certified to be Effective: 7-12-13 thru 1-7-14
Notice Publication Date:
Rules Amended: 111-030-0010, 111-030-0046
Rules Suspended: 111-030-0001, 111-030-0005, 111-030-0020, 111-030-0025
Subject: Removing development of benefit plans from rule, as this language applied to the OEBB benefit program when the program was in development. Benefit plan selection no longer applies since the Board made the decision to no longer restrict plans. Amendments made to plan selection criteria and the Health Savings Account section update new plans and plan requirements
Rules Coordinator: April Kelly—(503) 378-6588

111-030-0001
Development of OEBB Medical, Pharmaceutical, Dental and Vision Plan Designs

(1) As used in this section, "comparable plan design" means the actuarial value of the OEBB plan design is within 2.5 percent (higher or lower) than a current district plan.

(2) OEBB will develop plan designs for medical, pharmaceutical, dental and vision benefit plans that are comparable to the plan designs provided by Subject Districts prior to entering the OEBB.

(3) OEBB will develop comparable plan designs by:

(a) Collecting the medical, pharmaceutical, dental and vision plan designs provided by Subject Districts that will be entering OEBB on October 1, 2008, October 1, 2009, and October 1, 2010.

(4) Following initial implementation of the OEBB benefit plans on October 1, 2008, OEBB will re-evaluate its plan designs for the October 1, 2009, and October 1, 2010, plan year start dates to determine if the Subject District plan design was included in the comparability assessment performed for plan design development in 2008.

(a) If the Subject District plan design was considered during the initial plan design process no further analysis will be conducted.

(b) If the plan design was not considered during the initial plan design process OEBB will:

(A) Calculate the actuarial value for the Subject District plan design using an industry-standard actuarial model; and

(B) Identify whether a current OEBB plan design has an actuarial value 2.5 percent higher or lower than the Subject District plan design.

(5)(a) If none of the OEBB plan designs has an actuarial value within 2.5 percent higher or lower than the Subject District plan and the Subject District has 100 or more enrollees, OEBB will develop and implement a plan design with an actuarial value of 2.5 percent higher or lower than the Subject District's plan unless;

(b) There is an OEBB plan that has an actuarial value that is more than 2.5 percent higher than the Subject District's plan and it is determined that OEBB can still meet the comparable cost requirement.

Stat. Auth: ORS 243.860 - 243.886
Stats. Implemented: ORS 243.864
Hist.: OEBB 8-2008, f. 6-25-08, cert. ef. 6-26-08; OEBB 13-2009(Temp), f. & cert. ef. 7-31-09 thru 1-26-10; OEBB 20-2009, f. & cert. ef. 12-17-09; Suspended by OEBB 8-2013(Temp), f. & cert. ef. 7-12-13 thru 1-7-14

111-030-0005
Benefit Plans Selection through OEBB

(1) As used in this section, "benefit plans" includes medical, dental, pharmaceutical, dental, basic life and accidental death and dismemberment, optional life and AD&D, short and long term disability, long term care and employee assistance program.

(2) OEBB will offer a range of benefit plans that provide the flexibility to choose between a number of high quality plan options.

(3) The process for the 2012-13 Plan Year benefit plans selection includes:

(a) OEBB releases preliminary designs and costs for all benefit plan options to Educational Entities no later than 45 days prior to final selection date. The total number offered may vary each year.

(b) OEBB will pre-populate the MyOEBB Educational Entity Plan Management section with all medical, dental and vision plans available in the Educational Entity's service area.

(c) Educational Entities may choose to, or allow each Employee Group to choose to, de-select benefit plan options to be offered to each Employee Group unless otherwise specified in an OEBB administrative rule.

(d) Final benefit plan selections for each Employee Group must be submitted through the MyOEBB Educational Entity plan management section or an approved electronic format to OEBB no later than June 15 each year for the following plan year. Plan selections must be authorized by an official with the Educational Entity.

Stat. Auth: ORS 243.860–243.886
Stats. Implemented: ORS 243.864(1)(a)
Hist.: OEBB 8-2008, f. 6-25-08, cert. ef. 6-26-08; OEBB 13-2009(Temp), f. & cert. ef. 7-31-09 thru 1-26-10; OEBB 20-2009, f. & cert. ef. 12-17-09; OEBB 8-2010(Temp), f. & cert. ef. 8-3-10 thru 1-29-11; OEBB 2-2011, f. & cert. ef. 2-11-11; OEBB 3-2012(Temp), f. & cert .ef. 4-20-12 thru 10-16-12; OEBB 8-2012, f. & cert. ef. 10-9-12; Suspended by OEBB 8-2013(Temp), f. & cert. ef. 7-12-13 thru 1-7-14

111-030-0010
Medical, Pharmaceutical, Dental and Vision Plan Selection Criteria

Educational Entities may choose or allow all medical, dental and vision plans available in the service area to be available to some or all Entity Employee Groups with the following exceptions:

(1) The HMO vision plan offered through Kaiser Permanente is only available if the HMO medical plan offered through Kaiser Permanente is available.

(2) Moda Health Plan H can only be offered to employee groups who have the option to participate in a Health Savings Account (HSA) effective October 1, 2013.

Stat. Auth.: ORS 243.860–243.886
Stats. Implemented: ORS 243.864(1)(a))
Hist.: OEBB 8-2010(Temp), f. & cert. ef. 8-3-10 thru 1-29-11; OEBB 2-2011, f. & cert. ef. 2-11-11; OEBB 3-2012(Temp), f. & cert .ef. 4-20-12 thru 10-16-12; OEBB 8-2012, f. & cert. ef. 10-9-12; OEBB 8-2013(Temp), f. & cert. ef. 7-12-13 thru 1-7-14

111-030-0020
Development of OEBB Basic Life and Accidental Death and Dismemberment and Optional Life and Accidental Death and Dismemberment Plan Designs

(1) As used in this section, "comparable plan design" means that 90 percent of district employees can obtain a maximum benefit through an OEBB plan design that is within $2,500 of the maximum benefit obtained through a pre-OEBB plan design in effect the year prior to implementation.

(2) OEBB will develop plan designs for basic life and AD&D and optional life and AD&D benefit plans that are comparable to the plan designs provided by Subject Districts prior to entering the OEBB.

(3) OEBB will develop comparable plans by: Collecting plan designs for basic life and AD&D and optional life and AD&D plans provided by Subject Districts that enter OEBB on October 1, 2009, and October 1, 2010.

(4) Following initial implementation of the basic life and AD&D and optional life and AD&D benefit plans, OEBB will re-evaluate its plan designs for the October 1, 2010, plan year start date to determine if the Subject District plan design was included in the comparability assessment performed for plan design development.

(a) If the Subject District plan design was considered during the initial plan design process no further analysis will be conducted.

(b) If the plan design was not considered during the initial plan design process OEBB will:

(c) Identify whether a current OEBB plan design is within $2,500 higher or lower than the pre-OEBB life insurance or AD&D benefit level.

(5) If none of the OEBB plan designs is within $2,500 higher or lower than the pre-OEBB life insurance or AD&D benefit level and the Subject District has 100 or more enrollees, OEBB will develop and implement a plan design within $2,500 higher or lower than the pre-OEBB life insurance or AD&D benefit level unless;

(6) There is an OEBB plan that provides a benefit level more than $2,500 higher than the district's option and it is determined that OEBB can still meet the comparable cost requirement.

Stat. Auth.: ORS 243.860 - 243.886
Stats. Implemented: ORS 243.864(1)(a) & 243.868(1)

Hist.: OEBB 13-2009(Temp), f. & cert. ef. 7-31-09 thru 1-26-10; OEBB 20-2009, f. & cert. ef. 12-17-09; Suspended by OEBB 8-2013(Temp), f. & cert. ef. 7-12-13 thru 1-7-14

111-030-0025
Development of OEBB Short and Long Term Disability Plan Designs

(1) As used in the section, "comparable plan design" means 90 percent of the district employees can obtain the same elimination period, percentage of covered compensation, definition of covered compensation, coverage period duration, and maximum payment per benefit period through an OEBB plan design as through a pre-OEBB plan design in effect the year prior to implementation.

(2) OEBB will develop comparable plan designs by collecting plan designs for short and long term disability plans provided by Subject Districts that enter OEBB on October 1, 2009, and October 1, 2010.

(3) Following initial implementation of the short and long term disability benefit plans, OEBB will re-evaluate its plan designs for the October 1, 2010 plan year start date to determine if the Subject District plan design was included in the comparability assessment performed for plan design development.

(a) If the Subject District plan design was considered during the initial plan design process no further analysis will be conducted.

(b)(A) If the plan design was not considered during the initial plan design process OEBB will:

(B) Identify if a current OEBB plan design offers a level of benefits, elimination period, percentage of covered compensation, coverage period duration, and maximum payment per benefit period available through the group contract.

(4)(a) If none of the OEBB plan designs offers a level of benefits, elimination period, percentage of covered compensation, coverage period duration, and maximum payment per benefit period available through the group contract, OEBB will develop and implement a plan option that offers the level of benefits available through the Subject District unless;

(b) There is an OEBB benefit option that provides a benefit level or elimination period more generous than the district's option and it is determined that OEBB can still meet the comparable cost requirement.

Stat. Auth.: ORS 243.860 - 243.886
Stats. Implemented: ORS 243.864(1)(a) & 243.868(1)
Hist.: OEBB 13-2009(Temp), f. & cert. ef. 7-31-09 thru 1-26-10; OEBB 20-2009, f. & cert. ef. 12-17-09; Suspended by OEBB 8-2013(Temp), f. & cert. ef. 7-12-13 thru 1-7-14

111-030-0046
Development of Health Savings Accounts (HSA)

(1) Effective October 1, 2011, OEBB will offer the use of an employer sponsored vendor for Health Savings Accounts (HSA). For purposes of this rule, an HSA vendor will be considered employer sponsored if the Educational Entity offers:

(a) Employer contributions to the HSA; or

(b) Pre-tax or direct deposit of employee contributions to the HSA.

(2) If an Educational Entity chooses to offer an employer sponsored HSA, the Educational Entity may offer this plan through the OEBB-contracted HSA.

(3) Educational Entities may select or allow the HSA option to be available to eligible employees who enroll in OEBB's high-deductible health plan (HDHP) option (currently Moda Health Plan H).

(4) Eligible employees who are eligible to enroll in an HSA, and choose the employer sponsored HSA vendor, may do so directly through the HSA vendor or their Educational Entity.

(5) Eligible employees must meet requirements established by the Internal Revenue Service (IRS) to qualify for enrollment in an HSA. Once enrolled in an HSA, members are responsible to adhere to tax requirements of the IRS.

(6) Because IRS requirements for an individual to qualify for enrollment in an HSA include concurrent enrollment in a high-deductible health plan (HDHP), an Educational Entity that offers an employer sponsored HSA must offer its employees the choice of a HDHP option from among OEBB's medical plans (i.e., prior to the 2013-14 plan year, ODS Health Plan 9; beginning with the 2013-14 plan year, Moda Health Plan H). If an employee is enrolled in an OEBB medical plan other than OEBB's HDHP, the employee may not enroll in the OEBB HSA.

Stat. Auth.: ORS 243.860 - 243.886
Stats. Implemented: ORS 243.874(5)
Hist.: OEBB 13-20111(Temp), f. & cert. ef. 8-2-11 thru 1-28-12; OEBB 21-2011, f. 10-13-11, cert. ef. 10-14-11; OEBB 8-2013(Temp), f. & cert. ef. 7-12-13 thru 1-7-14

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Rule Caption: Establishes eligibility verification and reviews language under OEBB Operations rule
Adm. Order No.: OEBB 9-2013(Temp)
Filed with Sec. of State: 7-12-2013
Certified to be Effective: 7-12-13 thru 1-7-14
Notice Publication Date:
Rules Adopted: 111-080-0055
Subject: Currently, limited eligibility review language exists in Division 40 and Division 50 under OEBB's Chapter 111 rules. 111-080-0055 establishes eligibility verification and reviews language in rule under OEBB's Operations rule which elaborates on the different types of verifications and reviews and the timeline for such reviews.
Rules Coordinator: April Kelly—(503) 378-6588

111-080-0055
Eligibility Verifications and Reviews

(1) OEBB shall plan and conduct eligibility verifications and reviews to monitor compliance with OEBB administrative rules. Reviews shall include, but are not be limited to the following:

(a) Dependent eligibility;

(b) Employee eligibility;

(c) Election change limitations; and

(d) Plan enrollment limitations.

(2)(a) Employee eligibility, election change and plan enrollment reviews may occur on a random basis throughout the year, or if anomalies in data warrant a formal review.

(b) The Eligible Employee and educational entity are responsible to submit documentation upon request.

(3) Dependent eligibility verifications shall be completed at least once every three years per participating educational entity.

(a) OEBB shall develop a review plan that will include an onsite verification of dependent eligibility documentation for benefit-eligible employees of each participating educational entity once every three years.

(b) Educational entities may have a formal dependent eligibility verification and review completed by a third party vendor on or after October 1, 2013. The use of a third party vendor for a dependent eligibility verification and review may meet the once every three years requirement provided the vendor meets the standards and criteria set in the OEBB verification and review plan and agrees to report all findings to OEBB via a secure electronic file. All requests to substitute a third party vendor for this purpose must be pre-approved by OEBB.

(c) The member is responsible to submit documentation upon request. In the event the member does not provide the required documentation to sufficiently prove the dependent meets eligibility requirements, or the documentation provided is insufficient, the dependent's coverage will be terminated. Retroactive terminations may occur if the documentation provided shows the dependent was not eligible for coverage and the member misrepresented the dependent as being an eligible dependent as defined by OAR 111-080-0045.

Stat. Auth.: ORS 243.860 - 243.886
Stats. Implemented: ORS 243.864(1)(a)
Hist.: OEBB 9-2013(Temp), f. & cert. ef. 7-12-13 thru 1-7-14

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Oregon Health Authority, Public Health Division
Chapter 333

Rule Caption: Implementation of training of laypeople to recognize and treat opiate overdose
Adm. Order No.: PH 8-2013(Temp)
Filed with Sec. of State: 7-1-2013
Certified to be Effective: 7-1-13 thru 12-27-13
Notice Publication Date:
Rules Adopted: 333-055-0100, 333-055-0105, 333-055-0110
Subject: The Oregon Health Authority, Public Health Division is temporarily adopting administrative rules in chapter 333, division 55 to clarify the purpose of the training on lifesaving treatments for opiate overdose and to establish the protocols and criteria for training on lifesaving treatments for opiate overdose.
Rules Coordinator: Brittany Sande—(971) 673-1291

333-055-0100
Purpose

(1) The purpose of OAR 333-055-0100 through 333-055-0110 is to define the protocols and criteria for training on lifesaving treatments for opiate overdose.

(2) Nothing in these rules is meant to require training for health care professionals that are otherwise authorized to administer naloxone within their scope of practice.

(3) Opiate overdose requiring lifesaving treatment occurs in a wide variety of settings and circumstances, creating a need for training a variety of overdose responders. In recognition of this need, Oregon law authorizes a wide range of organizations to provide training on lifesaving treatments for opiate overdose including public health authorities, and organizations and other appropriate entities that provide services to individuals who take opiates. The Oregon Public Health Division interprets providing services to opiate users broadly and includes but is not limited to clinical, substance abuse, social services, public health, law enforcement and criminal justice, and other providers.

Stat. Auth: OL 2013, ch. 340
Stats. Implemented: OL 2013, ch. 340
Hist.: PH 8-2013(Temp), f. & cert. ef. 7-1-13 thru 12-27-13

333-055-0105
Definitions

Unless otherwise stated in rules 333-055-0100 through 333-055-0110, or the context of rules 333-055-0100 through 333-055-0110 requires otherwise, the following definitions apply to rules 333-055-0100 through 333-055-0110:

(1) "Certified nurse practitioner" means a nurse practitioner licensed under ORS Chapter 678.

(2) "Licensed physician" means a physician licensed under ORS chapter 677.

(3) "Opiate" has the same meaning given that term in Oregon Laws 2013, chapter 340.

(4) "Opiate overdose" has the same meaning given that term in Oregon Laws 2013, chapter 340.

Stat. Auth: OL 2013, ch. 340
Stats. Implemented: OL 2013, ch. 340
Hist.: PH 8-2013(Temp), f. & cert. ef. 7-1-13 thru 12-27-13

333-055-0110
Educational Training

(1) Training to administer naloxone must be subject to oversight by a licensed physician or certified nurse practitioner with prescriptive privileges. A licensed physician or certified nurse practitioner must ensure the training meets the protocols and criteria required in section (4) of this rule but is not required to be present during the training.

(2) Subject to the oversight required in section (1) of this rule, training may be conducted by a public health authority, an organization or other entity that provides services to individuals who take opiates.

(3) Individuals trained to respond to opiate overdose must be retrained at least every three years.

(4) The training must meet the protocols and criteria established by the Oregon Health Authority, Public Health Division. The approved training protocol and criteria for the treatment of opiate overdose is available on the Internet at http://public.health.oregon.gov/ProviderPartnerResources/EMSTraumaSystems/Pages/rules.aspx and is incorporated by reference.

Stat. Auth: OL 2013, ch. 340
Stats. Implemented: OL 2013, ch. 340
Hist.: PH 8-2013(Temp), f. & cert. ef. 7-1-13 thru 12-27-13

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Oregon Health Insurance Exchange
Chapter 945

Rule Caption: Qualified Health Plan Addendum for Indian Health Providers
Adm. Order No.: OHIE 4-2013
Filed with Sec. of State: 7-9-2013
Certified to be Effective: 7-9-13
Notice Publication Date: 6-1-2013
Rules Adopted: 945-020-0040
Subject: Adopts the Qualified Health Plan Addendum for Indian Health Care Providers, and requires insurers to use the addendum when contracting with Indian health providers for services to be offered as part of a plan certified by the Exchange as a qualified health plan.
Rules Coordinator: Gregory Jolivette—(503) 373-9406

945-020-0040
Qualified Health Plan Addendum for Indian Health Care Providers

(1) The Exchange adopts by reference the Qualified Health Plan (QHP) Addendum for Indian Health Care Providers.

(2) If a health insurer contracts with a Tribal Health Provider in the state of Oregon for services to be offered through a health benefit plan certified by the Exchange as a QHP, the issuer must:

(a) Use the QHP Addendum for Indian Health Care Providers to supplement and amend their existing provider contract, and

(b) Notify the Exchange of the contractual relationship by contacting an Exchange carrier account executive.

(3) The Exchange reserves the right to amend the QHP Addendum for Indian Health Care Providers using the rulemaking process. Contracted carriers and tribes will be required to amend their contracts to reflect any change to the QHP Addendum for Indian Health Care Providers within 90 days of adoption of the change.

Stat. Auth.: ORS 741.002
Stats. Implemented: ORS 741.310
Hist.: OHIE 4-2013, f. & cert. ef. 7-9-13

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Oregon Health Licensing Agency
Chapter 331

Rule Caption: Establish fee for temporary licensure and repeal trainee registration fee.
Adm. Order No.: HLA 9-2013
Filed with Sec. of State: 7-1-2013
Certified to be Effective: 7-1-13
Notice Publication Date: 5-1-2013
Rules Ren. & Amend: 331-405-0030 to 331-440-0000
Subject: Establish application and license fee for temporary license and repeal trainee registration fee.

House Bill 2045 was approved during the 2011 Legislative Session giving permissive authority to the Oregon Health Licensing Agency to establish a temporary license. The fees were established through the agency's budget, House Bill 5026-policy package 203.

Administrative rules are being established for a temporary license to allow individuals who have obtained the required education and training to continue to gain competency while waiting to take the board approve practical examination. The practical examination is held one time per year.

The trainee registration fee is being repealed to align with statutory requirements.

Rules Coordinator: Samantha Patnode—(503) 373-1917

331-440-0000
Fees

(1) Applicants and licensees are subject to the provisions of OAR 331-010-0010 and 331-010-0020 regarding the payment of fees, penalties and charges.

(2) Fees established by the Oregon Health Licensing Agency are as follows:

(a) Application:
(A) License: $350.
(B) License by reciprocity: $450.
(C) Temporary license: $50
(b) Examination:
(A) Oregon laws & rules: $50.
(B) Written: $350.
(C) Practical: $650.
(c) Original issuance:
(A) License: $700
(B) Temporary license: $50
(d) Renewal:
(A) License: $700
(B) Temporary license: $50

(e) Delinquent (late) renewal of license: $25 for the first month in expired status, and $10 each month thereafter while in an expired status.

(f) Replacement of license, including name change: $25.

(g) Duplicate license document: $25 per copy with maximum of three.

(h) Affidavit of licensure: $50.

(i) An additional $25 Administrative Processing fee will be assessed if a NSF or non-negotiable instrument is received for payment of fees, penalties and charges. Refer to OAR 331-010-0010.

Stat. Auth.: ORS 676.605, 676.615 & 680.525
Stats. Implemented: ORS 676.605, 676.615 & 680.525
Hist.: HD 11-1979(Temp), f. & ef. 8-23-79; HD 2-1980, f. & ef. 2-14-80; HD 11-1981(Temp), f. & ef. 7-15-81; HD 9-1985(Temp), f. & ef. 5-24-85; HD 15-1985, f. & ef. 9-

4-85; HD 25-1988(Temp), f. & cert. ef. 11-1-88; HD 4-1989, f. & cert. ef. 6-1-89; HD 13-1991(Temp), f. & cert. ef. 9-30-91; HD 3-1992, f. & cert. ef. 3-25-92; HD 22-1993, f. 12-30-93, cert. ef. 1-1-94; HDLP 3-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 333-020-0035; HDLP 1-2001, f. 3-21-01, cert. ef. 4-1-01; HLO 3-2003, f. 5-6-03, cert. ef. 5-15-03; HLO 2-2004, f. 6-29-04, cert. ef. 7-1-04; HLO 2-2005, f. 12-15-05, cert. ef. 1-1-06; HLA 5-2008, f. 9-15-08, cert. ef. 10-1-08; Renumbered from 331-405-0030, HLA 9-2013, f. & cert. ef. 7-1-13

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Rule Caption: Adopt qualifications for temporary licensure; align rules with current standards including informed consent documentation.

Adm. Order No.: HLA 10-2013

Filed with Sec. of State: 7-1-2013

Certified to be Effective: 7-1-13

Notice Publication Date: 4-1-2013

Rules Adopted: 331-410-0012, 331-410-0015, 331-410-0025, 331-410-0035, 331-410-0045, 331-410-0055

Rules Amended: 331-405-0020, 331-410-0020, 331-410-0030, 331-410-0050, 331-410-0060, 331-410-0065, 331-410-0080, 331-410-0090, 331-415-0010, 331-415-0020, 331-420-0000, 331-420-0010, 331-420-0020, 331-430-0030

Rules Repealed: 331-405-0045, 331-410-0010, 331-410-0040, 331-415-0000, 331-425-0010

Rules Ren. & Amend: 331-410-0000 to 331-407-0000

Subject: Adopt, amend and repeal rules to align with current industry, agency and statewide rulemaking standards and principles. Administrative rules have been streamlined to be consistent with statutory authority and Agency protocol.

Amendments provide requirements for approval of educational institutions with associate degree in denture technology or the equivalent including the specific courses required and the minimum number of credits per course The rule also recognizes that some education programs may have associated clinical practice experience (1,000 hours) within the program.

Require supervisors of trainees notify the agency when a new individual is ready to commence training. Require the supervisor provide direct supervision when the trainee is providing direct patient care and indirect supervision when the trainee is performing laboratory duties. Amendments include timeline, supervision requirements and notification of changes. The board currently requires trainees register that they are training however ORS 680.510 exempts certain individuals from licensure. Requiring the trainee register is outside the statutory authority of the board or agency; however since a supervisor is a licensee the board can require the supervisor notify the agency if they are supervising an individual.

Amendments outline specific requirements for the 1,000 hours supervised clinical practice in denture technology including 400 hours of direct patient care and construction of 40 removable dentures pursuant to ORS 680.515(1)(a).

Adopt rules which allow an individual who has completed an approved education program, 1,000 of of supervised clinical practice in denture technology and a written examination to obtain a temporary license. Rule includes directives for indirect supervision, timeline for notification, supervision requirements and notification of changes.

Adopt rules which specify requirements for being an approved supervisor for temporary licensees. Rule also provides supervision requirements for individuals obtaining additional work experience in order to qualify to retake the practical examination.

Licensing requirements for a full denture technology license has been streamlined to be consistent with statutory authority and agency protocol. The proposed rules address application requirements, including examinations, for the following pathways to become licensed as a denture technologist:

1) Pathway 1: Pathway 1: Qualification through Associate's Degree Program or Equivalent Education with 1,000 hours Supervised Clinical Practice in Denture Technology

2) Pathway 2: Reciprocity

Amend general examination information including the written and practical examinations

approved by the board which is available on the agency Website. Rule provides for requirements to retake the written and practical examination.

Rule specifies certain requirements be met to be scheduled to take the practical examination including meeting education and 1,000 hours supervised clinical practice in denture technology as well as meeting requirements 60 days before the examination. Rule also requires practical examination candidates provide certain information at the time of the practical examination including photographic identification for candidate and patient, an interpreter if the patient does not speak English and an oral health certificate for the patient on a form prescribed by the agency.

Rule changes include standardizing renewal requirements to describe a license as active, inactive or expired and the process for renewal including continuing education requirements. Adopt rule delineating licensure posting requirements including the ability to obtain a duplicate license and align continuing education requirements with current agency and industry standards.

Amend practice standards, to include providing written and verbal information and obtain informed consent to patients purchasing teeth whitening trays. Prohibit denturists from providing teeth whitening solutions which are prescription strength. Eliminate minimum standards of acceptability for full dentures to allow flexibility to denturists to provide appropriate services to clients and allow the agency to use the current industry standards when investigating a complaint for full or partial dentures.

Amend business premises requirements to include surface materials and appropriate surface disinfecting, maintenance of service areas, equipment, restrooms and other public areas. Require standards for disposal of contaminated waste and sharp objects. Align sterilization and disinfection process with current denture technology standards including use of high level disinfectants or autoclaves sterilizers. Require denturists who utilize an autoclave perform biological testing of the autoclave monthly. As of July 1, 2014 denturists must sterilize all reusable instruments by use of an autoclave.

Repeal certain administrative rules which are generally handled through the contested case process or other agency/board policy. Revise civil penalty standards.

Rules Coordinator: Samantha Patnode—(503) 373-1917

331-405-0020
Definitions

The following definitions apply to OAR chapter 331, divisions 405 through 430:

(1) "Affidavit of Licensure" the meaning is set forth in OAR 331-030-0040.

(2) "Agency" means the Oregon Health Licensing Agency.

(3) "Board" means the State Board of Denture Technology.

(4) "Direct supervision" means the supervisor is immediately accessible and onsite at the business when denture technology services are performed.

(5) "High level disinfectant" means a chemical agent, which has demonstrated tuberculocidal activity and is registered with the Environmental Protection Agency.

(6) "Indirect supervision" means the supervisor is available by phone or by other means of electronic communication. The supervisor must be able to reasonably oversee the work of the individual being supervised, and be available for questions and assistance when needed.

(7) "Informed Consent" means the written consent obtained following a thorough and easily understood explanation to the patient, or patient's guardian, of the proposed procedures, any available alternative procedures and any risks associated with the procedures. Following the explanation,

the licensee must ask the patient, or the patient's guardian, if there are any questions. The licensee must provide thorough and easily understood answers to questions asked.

(8) "Official transcript" means an original document authorized by the appropriate office in the Oregon Department of Education and certified by a college, university or private career school indicating applicant identity information, hours and types of course work, examinations and scores that the student has completed. Original documents must be submitted directly to the Agency from the college, university or private career school by United States Postal Service mail, or other recognized mail service providers, in a sealed envelope.

(9) "1,000 hours of supervised clinical practice in denture technology" means engaging in clinical and laboratory training in denture technology within an Agency approved education or work experience program. The program must include:

(a) Clinical: a minimum of 400 hours in direct patient care in denture technology; and

(b) Laboratory: construction of a minimum of 40 removable dentures, on 40 different patients. Each removable denture will be counted as one denture; an upper and a lower removable denture counts as two removable dentures.

Stat. Auth.: ORS 680.565
Stats. Implemented: ORS 680.565
Hist.: HD 11-1979(Temp), f. & ef. 8-23-79; HD 2-1980, f. & ef. 2-14-80; HD 12-1981(Temp), f. & ef. 7-15-81; HD 1-1983, f. & ef. 1-20-83; HD 4-1988, f. & cert. ef. 3-4-88; HD 25-1988 (Temp), f. & cert. ef. 11-1-88; HD 4-1989, f. & cert. ef. 6-1-89; HD 10-1989, f. & cert. ef. 11-21-89; HD 13-1991(Temp), f. & cert. ef. 9-30-91; HD 3-1992, f. & cert. ef. 3-25-92; HD 22-1993, f. 12-30-93, cert. ef. 1-1-94; HDLP 3-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 333-020-0005; HDLP 1-2001, f. 3-21-01, cert. ef. 4-1-01; HLO 1-2003, f. 1-21-03, cert. ef. 2-1-03; HLO 2-2004, f. 6-29-04, cert. ef. 7-1-04; HLO 2-2005, f. 12-15-05, cert. ef. 1-1-06; HLA 10-2013, f. & cert. ef. 7-1-13

331-407-0000
Approved Education and 1,000 Hours of Clinical Practice Experience in Denture Technology

(1) To be approved as an educational program with 1,000 hours equivalent educational program with 1,000 hours supervised clinical practice in denture technology as defined under OAR 331-405-0020 including private career schools, which is equivalent to an associate's degree, the provider of the educational program must submit documentation which meets the requirements of ORS 680.515(1)(a) and the Board's approved Denture Technology Curriculum Objectives which can be obtained on the Agency Website at http://www.oregon.gov/OHLA/DT/pages/index.aspx. This documentation must prove that the educational program has a minimum of 103 credits in quarter hours or equivalent hours in the following educational areas:

(a) Orofacial Anatomy a minimum of 2 credits;

(b) Dental Histology and Embryology a minimum of 2 credits;

(c) Pharmacology a minimum of 3 credits;

(d) Emergency Care or Medical Emergencies a minimum of 1 credit;

(e) Oral Pathology a minimum of 3 credits;

(f) Pathology emphasizing in Periodontology a minimum of 2 credits;

(g) Dental Materials a minimum of 5 credits;

(h) Professional Ethics and Jurisprudence a minimum of 1 credit;

(i) Geriatrics a minimum of 2 credits;

(j) Microbiology and Infection Control a minimum of 4 credits;

(k) Clinical Denture Technology a minimum of 16 credits which may be counted towards 1,000 hours supervised clinical practice in denture technology defined under OAR 331-405-0020(9);

(l) Laboratory Denture Technology a minimum of 37 credits which may be counted towards 1,000 hours supervised clinical practice in denture technology defined under OAR 331-405-0020(9);

(m) Nutrition a minimum of 4 credits;

(n) General Anatomy and Physiology minimum of 8 credits; and

(o) General education and electives a minimum of 13 credits.

(2) The provider of the educational program must also submit the following:

(a) Documentation of the educational institution's accreditation, if any;

(b) Documentation from the Department of Education of any certification of the educational institution, if it is a private career school;

(c) A list of the educational materials and books required for all of the courses listed in subsection (1) of this rule;

(d) Lecture and lab hours required in the courses at the institution, as they equate to standard academic credit hours;

(e) Any additional information or documentation requested by the Agency.

Stat. Auth.: ORS 676.605, 676.615 & 680.515
Stats. Implemented: ORS 676.605, 676.615 & 680.515
Hist.: HD 11-1979(Temp), f. & ef. 8-23-79; HD 2-1980, f. & ef. 2-14-80; HD 1-1983, f. & ef. 1-20-83; HD 4-1989, f. & cert. ef. 6-1-89; HD 10-1989, f. & cert. ef. 11-21-89; HD 13-1991(Temp), f. & cert. ef. 9-30-91; HD 3-1992, f. & cert. ef. 3-25-92; HD 22-1993, f. 12-30-93, cert. ef. 1-1-94; HDLP 3-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 333-020-0040; HDLP 1-2001, f. 3-21-01, cert. ef. 4-1-01; HLO 1-2003, f. 1-21-03, cert. ef. 2-1-03; HLO 2-2004, f. 6-29-04, cert. ef. 7-1-04; HLO 2-2005, f. 12-15-05, cert. ef. 1-1-06; Renumbered from 331-410-0000, HLA 10-2013, f. & cert. ef. 7-1-13

331-410-0012
Denture Technology Supervisors

(1) To be approved as a supervisor pursuant to ORS 680.510, 680.515(1)(a) and 680.515(1)(c) an individual must:

(a) Hold a valid dentist license under ORS 679 or valid denturist license under ORS 680 and OAR 331-410-0030;

(b) Hold an oral pathology endorsement if supervisor is a denturist licensed under ORS 680 and OAR 331-410-0030; and

(c) Have no current or pending disciplinary action imposed by the Agency or other regulatory body;

(d) Submit proof of having been actively practicing denture technology for at least three years prior to requesting approval as a supervisor;

(e) Submit a completed request for approval on a form prescribed by the Agency.

(2) An approved supervisor may not supervise until all required documentation has been completed and submitted to the Agency and the supervisor has received Agency approval.

(3) An approved supervisor may supervise up to two individuals whether the individuals;

(4) An approved supervisor must provide direct supervision defined under OAR 331-405-0020(4) when direct patient care is being provided as listed in ORS 680.500(3)(b). The supervisor is responsible for guiding and monitoring the performance of the individual being supervised.

(5) An approved supervisor may provide indirect supervision defined under OAR 331-405-0020(6) when laboratory services are being performed as listed under ORS 680.500(3)(a).

(6) An approved supervisor must notify the Agency in writing within 10 calendar days if an individual is no longer being supervised, and must provide the number of hours of training completed on a form prescribed by the Agency.

(7) An approved supervisor must obtain signed informed consent from all patients before an individual obtaining training performs services on the patient.

(8) An approved supervisor must ensure that an individual obtaining training is clearly identified to patients.

(9) An approved supervisor must exercise management, guidance, and control over the activities of an individual obtaining training and must exercise professional judgment and be responsible for all matters related to the practice of denture technology.

(10) An approved supervisor must maintain training documentation, including documentation with handwritten signature of the supervisor and supervisor's license number. Training documentation must be kept on the business premises for a minimum of two years.

(11) An approved supervisor must adhere to all practice standards listed in OAR 331 Division 420.

(12) An approved supervisor may only provide two years of direct supervision to each individual obtaining training pursuant to ORS 680.510(3).

(13) Agency approval of a supervisor may be withdrawn if the supervisor provides incomplete or inadequate training during supervision or falsifies documentation.

Stat. Auth.: ORS 676.605, 676.615 & 680.515
Stats. Implemented: ORS 676.605, 676.615 & 680.515
Hist.: HLA 10-2013, f. & cert. ef. 7-1-13

331-410-0015
Denture Technology Temporary License

(1) A denture technology temporary license authorizes the holder to temporarily practice denture technology pursuant to ORS 680.515 following completion of an Associate's degree or equivalent education in denture technology and 1,000 hours of supervised clinical practice in denture technology listed in ORS 680.515 and defined under OAR 331-405-0020(9) while under supervision of a supervisor approved under OAR 331-410-0012.

(2) A denture technology temporary license is valid for one year and may be renewed one time.

(3) A denture technology temporary licensee may work under indirect supervision as defined under OAR 331-405-0020(6).

(4) A denture technology temporary license holder must notify the Agency within 10 calendar days of changes in employment status or changes in supervisor status.

(5) A denture technology temporary license is invalid after passage of the written and practical examination.

(6) A denture technology temporary license holder who changes supervisors more than three times must receive approval from the Board prior to making a fourth or subsequent change.

(7) A denture technology temporary license holder must adhere to all practice standards listed in OAR 331 Division 420.

Stat. Auth.: ORS 680.515 & 680.565
Stats. Implemented: ORS 680.515 & 680.565
Hist.: HLA 10-2013, f. & cert. ef. 7-1-13

331-410-0020
Application Requirements for Denture Technology Temporary License

An applicant for a denture technology temporary license must:

(1) Meet the requirements of OAR chapter 331 Division 30;

(2) In addition to requirements listed in subsections (1), an applicant must provide documentation of one of the following pathways:

(a) **License Pathway 1** — Qualification through Associate's Degree Program or equivalent education with 1,000 hours supervised clinical practice in denture technology within the education program. The applicant must submit:

(A) Official transcript, as defined in OAR 331-405-0020, demonstrating completion of an Agency approved Associate's degree in denture technology or equivalent education listed under OAR 331-407-0000. The official transcript must document completion of 1,000 hours supervised clinical practice defined under OAR 331-405-0020(9);

(B) Proof of having completed and passed a Board approved written examination within two years before the date of application.

(C) Supervisor information on a form prescribed by the Agency.

(b) **License Pathway 2** — Qualification through Associate's Degree Program or equivalent education with 1,000 hours supervised clinical practice in denture technology under an approved supervisor. The applicant must submit:

(A) Official transcript, as defined in OAR 331-405-0020, demonstrating completion of an Agency approved Associate's degree in denture technology or equivalent education listed under OAR 331-407-0000;

(B) Documentation of 1,000 hours supervised clinical practice defined under OAR 331-405-0020(9) under an approved supervisor pursuant to OAR 331-410-0012 on a form prescribed by the Agency;

(C) Proof of having completed and passed a Board approved written examination within two years before the date of application; and

(D) Supervisor information on a form prescribed by the Agency.

Stat. Auth.: ORS 680.515 & 680.565
Stats. Implemented: ORS 680.515 & 680.565
Hist.: HD 11-1979(Temp), f. & ef. 8-23-79; HD 2-1980, f. & ef. 2-14-80; HD 25-1989(Temp), f. & cert. ef. 11-1-88; HD 4-1989, f. & cert. ef. 6-1-89; HD 10-1989, f. & cert. ef. 11-21-89; HD 13-1991(Temp), f. & cert. ef. 9-30-91; HD 3-1992, f. & cert. ef. 3-25-92; HD 22-1993, f. 12-30-93, cert. ef. 1-1-94; HDLP 3-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 333-020-0015; HDLP 1-2001, f. 3-21-01, cert. ef. 4-1-01; HDLP 1-2002, f. 5-31-02, cert. ef 6-1-02; HLO 2-2004, f. 6-29-04, cert. ef. 7-1-04; HLO 2-2005, f. 12-15-05, cert. ef. 1-1-06; HLA 10-2013, f. & cert. ef. 7-1-13

331-410-0025
Denture Technology Supervisor for a Denture Technology Temporary Licensee

(1) To be approved as a supervisor pursuant to ORS 680.515 of a denture technology temporary licensee under 331-410-0015, an individual must:

(a) Hold a valid dentist license under ORS 679 or valid denturist license under ORS 680 and OAR 331-410-0030;

(b) Have no current or pending disciplinary action imposed by the Agency or other regulatory body;

(c) Submit proof of having been actively practicing denture technology for at least three years prior to requesting approval as a supervisor;

(d) Hold an oral pathology endorsement if supervisor is a denturist licensed under ORS 680 and OAR 331-410-0030; and

(e) Submit a completed request for approval on forms prescribed by the Agency.

(2) A supervisor may not supervise a denture technology temporary licensee until all required documentation has been completed and submitted to the Agency and the supervisor has received Agency approval.

(3) A supervisor may supervise up to two individuals whether the individuals are denture technology trainees or denture technology temporary licensees;

(4) An approved supervisor of a denture technology temporary licensee may provide indirect supervision defined under OAR 331-405-0020 when direct patient care is being provided as listed in ORS 680.500(3)(b) or when laboratory services are performed as listed under ORS 680.500(3)(a).

(5) An approved supervisor must notify the Agency in writing within 10 calendar days if a denture technology temporary licensee is no longer being supervised, and must provide the number of hours of training completed on a form prescribed by the Agency.

(6) An approved supervisor must obtain signed informed consent from all patients before a denture technology temporary licensee performs services on the patient.

(7) An approved supervisor must ensure that all denture technology trainees are clearly identified to patients.

(8) A designated supervisor must exercise management, guidance, and control over the activities of the temporary licensee and must exercise professional judgment and be responsible for all matters related to the temporary licensees practice of denture technology.

(9) The supervisor must maintain training documentation on the business premises for a minimum of two years.

(10) Agency approval of a supervisor may be withdrawn if the supervisor provides incomplete or inadequate training during supervision or falsifies documentation.

(11) An approved supervisor must adhere to all practice standards listed in OAR 331 Division 420.

Stat. Auth.: ORS 680.515 & 680.565
Stats. Implemented: ORS 680.515 & 680.565
Hist.: HLA 10-2013, f. & cert. ef. 7-1-13

331-410-0030
Denture Technology License

(1) A denture technology license holder, licensed under ORS 680.505, may practice denture technology defined under ORS 680.500.

(2) A denture technology license is good for one year, and is eligible for renewal. The denture technology license becomes inactive on the last day of the month one year from the date of issuance.

(3) A licensed denturist must adhere to all practice standards listed in OAR 331 division 420.

Stat. Auth.: ORS 680.520 & 680.565
Stats. Implemented: ORS 680.520 & 680.565
Hist.: HD 11-1979(Temp), f. & ef. 8-23-79; HD 2-1980, f. & ef. 2-14-80; HD 1-1983, f. & ef. 1-20-83; HD 25-1988(Temp), f. & cert. ef. 11-1-88; HD 4-1989, f. & cert. ef. 6-1-89; HD 10-1989, f. & cert. ef. 11-21-89; HD 13-1991(Temp), f. & cert. ef. 9-30-91; HD 3-1992, f. & cert. ef. 3-25-92; HD 22-1993, f. 12-30-93, cert. ef. 1-1-94; HDLP 3-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 333-020-0030; HDLP 1-2001, f. 3-21-01, cert. ef. 4-1-01; HDLP 5-2001, f. & cert. ef. 12-14-01; HDLP 1-2002, f. 5-31-02, cert. ef 6-1-02; HLO 2-2004, f. 6-29-04, cert. ef. 7-1-04; HLO 2-2005, f. 12-15-05, cert. ef. 1-1-06; HLA 10-2013, f. & cert. ef. 7-1-13

331-410-0035
Application Requirements for Denture Technology Licensure

An individual applying for a license in denture technology must:

(1) Meet the requirements of OAR 331 Division 30.

(2) Submit a completed application form prescribed by the Agency, which must contain the information listed in OAR 331-030-0000 and be accompanied by payment of all required fees.

(3) In addition to requirements listed in subsections (1) and (2) of this rule, an applicant must provide documentation of one of the following pathways:

(a) **License Pathway 1** — Qualification through Associate's Degree Program or equivalent education with 1,000 hours supervised clinical practice in denture technology within the education program. The applicant must submit:

(A) Official transcript, as defined in OAR 331-405-0020, demonstrating completion of an Agency approved Associate's degree in denture technology or equivalent education listed under OAR 331-407-0000. The official transcript must document completion of 1,000 hours supervised clinical practice defined under OAR 331-405-0020(9);

(B) Proof of having completed and passed a Board approved practical examination within two years before the date of application; and

(C) Proof of having completed and passed a Board approved written examination within two years before the date of application.

(D) An applicant is not required to provide official transcript or proof of having completed and passed a Board approved written examination if the applicant obtained a denture technology temporary license within two years from the date of application for a full denture technology license.

(b) **License Pathway 2** — Qualification through Associate's Degree Program or equivalent education with 1,000 hours supervised clinical prac-

tice in denture technology under an approved supervisor. The applicant must submit:

(A) Official transcript, as defined in OAR 331-405-0020, demonstrating completion of an Agency approved Associate's degree in denture technology or equivalent education listed under OAR 331-407-0000;

(B) Documentation of 1,000 hours supervised clinical practice defined under OAR 331-405-0020(9) under an approved supervisor pursuant to on a form prescribed by the Agency.

(C) Proof of having completed and passed a Board approved practical examination within two years before the date of application;

(D) Proof of having completed and passed a Board approved written examination within two years before the date of application; and

(D) An applicant is not required to provide official transcript, documentation of 1,000 hours supervised clinical practice under an approved supervisor or proof of having completed and passed a Board approved written examination if the applicant obtained a denture technology temporary license within two years from the date of application for a full denture technology license.

(c) **License Pathway 3** — Reciprocity. The applicant must submit:

(A) Official transcript or transcripts as defined in OAR 331-405-0020 demonstrating completion of qualifying Associate's degree or equivalent education, as described in OAR 331-410-0010;

(B) An affidavit of licensure pursuant to OAR 331-405-0020(1), demonstrating proof of current licensure as a denturist, which is active with no current or pending disciplinary action. The license must have been issued by a another state, the District of Columbia, a United States Territory, or Canada, and that jurisdiction's denturist licensing standards must be substantially equivalent to those of Oregon, as determined by the Agency;

(C) Documentation of having successfully passed both written and practical denturist examinations, which are substantially equivalent to those required for licensure in Oregon, as determined by the Agency;

(D) Documentation of having engaged in full-time denturist practice in the applicant's reciprocal licensure jurisdiction for at least two years immediately before the date of application for licensure in Oregon, on a from prescribed by the Agency.

Stat. Auth.: ORS 680.515 & 680.565
Stats. Implemented: ORS 680.515 & 680.565
Hist.: HLA 10-2013, f. & cert. ef. 7-1-13

331-410-0045
Examination Information

(1) The Oregon licensing examination consists a written and a practical examination. A list of Board approved written and practical examinations can be accessed on the Agency Website at http://www.oregon.gov/OHLA/DT/pages/index.aspx.

(2) The written examination is comprised of multiple-choice questions covering subject areas specified in ORS 680.515(1)(a) and questions on the Oregon laws and rules regulating the practice of denture technology.

(3) The practical examination requires the applicant to demonstrate skills required to practice denture technology, including but not limited to: final impression and model and trial dentures.

(4) To be eligible for examination, an applicant must meet identification requirements listed under OAR 331-030-0000.

(5) The examination is administered in English only, unless an Agency approved testing contractor or vendor provides the examination in languages other than English.

(6) Examination candidates may be electronically monitored during the course of testing.

(7) Examination candidates must adhere to the maximum time allowance for each section of the examination, as established by the Agency.

(8) Taking notes, textbooks or notebooks into the examination area is prohibited.

(9) Electronic equipment and communication devices, such as personal computers, pagers and cellular telephones or any other devices deemed inappropriate by the Agency, are prohibited in the examination area.

(10) Candidate conduct that interferes with the examination may result in the candidate's disqualification during or after the examination, the candidate's examination being deemed invalid, and forfeiture of the candidate's examination fees. Such conduct includes but is not limited to:

(a) Directly or indirectly giving, receiving, soliciting, and attempting to give, receive or solicit aid during the examination process;

(b) Violations of subsections (8) or (9) of this rule;

(c) Removing or attempting to remove any examination-related information, notes or materials from the examination site;

(d) Failing to follow directions relative to the conduct of the examination; and

(e) Exhibiting behavior that impedes the normal progress of the examination.

(11) If the candidate is disqualified from taking the examination or the candidate's examination is deemed invalid for reasons under subsection (10) of this rule, the candidate may be required to reapply, submit additional examination fees, and request in writing to schedule a new examination date, before being considered for another examination opportunity.

Stat. Auth.: ORS 680.515 & 680.565
Stats. Implemented: ORS 680.515 & 680.565
Hist.: HLA 10-2013, f. & cert. ef. 7-1-13

331-410-0050
Qualification and Requirements for Practical Examination

(1) To be qualified to take the board administered practical examination the individual must submit official transcripts and documentation of 1,000 hours supervised clinical practice listed in OAR 331-410-0035(3)(a);

(2) To be scheduled to take the board administered practical examination, applicants must submit a form prescribed by the Agency and pay required fees at least 60 calendar days prior to the examination date.

(3) A practical examination candidate must provide the following at the time of practical examination:

(a) Government issued photographic identification listed under OAR 331-030-0000 proving that the practical examination candidate is the individual scheduled to take the practical examination;

(b) Government issued identification proving the patient is 18 years of age. See identification options under ORS 331-030-0000;

(c) An oral health certificate for the patient signed by a dentist , physician, nurse practitioner or a licensed denturist with the oral pathology endorsement, within 30 days of the practical examination, stating the patient's oral cavity is substantially free from disease and mechanically sufficient to receive a denture; and

(d) Agency prescribed practical examination candidate and patient forms.

(4) The patient must be completely edentulous;

(5) If a patient does not speak English the candidate for practical examination must ensure an interpreter is available for examination proctors to communicate with patient. The interpreter is prohibited from being the practical examination candidate. Any costs incurred for interpreter services are the responsibility of the practical examination candidate.

(6) A practical examination candidate may be disqualified from taking the practical examination if any requirements of this rule are not met.

Stat. Auth.: ORS 680.520 & 680.565
Stats. Implemented: ORS 680.520 & 680.565
Hist.: HDLP 3-1998, f. 6-26-98, cert. ef. 7-1-98; HDLP 1-2001, f. 3-21-01, cert. ef. 4-1-01; HLO 2-2004, f. 6-29-04, cert. ef. 7-1-04; HLA 10-2013, f. & cert. ef. 7-1-13

331-410-0055
Written Examination Retake Requirements

(1) Failed sections of the written examination may be retaken as follows:

(a) After first failed attempt — applicant may not retake until the Agency's next business day;

(b) After second failed attempt — applicant may not retake for seven business days;

(c) After third failed attempt — applicant may not retake for 30 business days, must pay all additional fees and submit documentation showing completion of additional theory and laboratory training hours in denture technology in accordance with the percentage of questions failed in each domain under an approved supervisor pursuant to OAR 331-410-0012.

(d) After fourth failed attempt — applicant may not retake until the Agency's next business day;

(e) After fifth failed attempt — applicant may not retake for seven business days;

(f) After sixth failed attempt — applicant may not retake for 30 business days, must pay all additional fees and submit documentation showing completion of additional theory and laboratory training hours in denture technology in accordance with the percentage of questions failed in each domain under an approved supervisor pursuant to OAR 331-410-0012.

(g) After seventh failed attempt — ability to retake, requirements for retake, or both will be determined by the Board on a case-by-case basis.

(2) Applicants retaking the examination must meet the requirements under OAR 331-030-0000.

Stat. Auth.: ORS 680.515 & 680.565
Stats. Implemented: ORS 680.515 & 680.565
Hist.: HLA 10-2013, f. & cert. ef. 7-1-13

331-410-0060
Practical Examination Retake Requirements

(1) Pursuant to ORS 680.515(1)(c) an applicant failing the following portions of the practical examination must obtain the following additional clinical and laboratory training hours within two years from the date of the failed practical examination:

(a) Final impression and model: 50 hours of direct patient care and laboratory training consisting of production of 10 removable dentures;

(b) Trial denture centric relation: 150 hours in direct patient care and laboratory training consisting of production of 16 removable dentures;

(c) Trial dentures vertical relation: 150 hours in direct patient care laboratory training consisting of production of 16 removable dentures;

NOTE: Each removable denture will be counted as one denture; an upper and a lower removable denture counts as two removable dentures.

(2) An applicant failing any portion of the practical examination must apply and qualify for a temporary denture technology license under OAR 331-410-0015 and 331-410-0020 before commencing direct patient care;

(3) An applicant must submit documentation approved by the Agency upon completion of additional clinical and laboratory training hours pursuant to ORS 680.515(1)(c). Upon Agency approval of additional training an applicant may be scheduled to take the practical examination at a date and time approved by the Board.

(4) An applicant applying to retake the practical examination must meet the requirements of 331-410-0050.

Stat. Auth.: ORS 676.605, 676.615, 680.525, 680.530 & 680.565
Stats. Implemented: ORS 676.605, 676.615, 680.525, 680.530 & 680.565
Hist.: HD 25-1988(Temp), f. & cert. ef. 11-1-88; HD 4-1989, f. & cert. ef. 6-1-89; HD 13-1991(Temp), f. & cert. ef. 9-30-91; HD 3-1992, f. & cert. ef. 3-25-92; HD 22-1993, f. 12-30-93, cert. ef. 1-1-94; HDLP 3-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 333-020-0032; HDLP 1-2001, f. 3-21-01, cert. ef. 4-1-01; HDLP 1-2002, f. 5-31-02, cert. ef 6-1-02; HLO 2-2004, f. 6-29-04, cert. ef. 7-1-04; HLA 10-2013, f. & cert. ef. 7-1-13

331-410-0065
License Renewal

(1) A licensee is subject to the provisions of OAR Chapter 331, Division 30 regarding the renewal of a license, and provisions regarding authorization to practice, identification, and requirements for issuance of a duplicate license.

(2) License renewal under this rule is valid for one year.

(3) LICENSE RENEWAL: To avoid delinquency penalties, license renewal must be made prior to the license entering inactive status. The licensee must submit the following:

(a) Renewal application form;

(b) Payment of required renewal fee pursuant to OAR 331-440-0000; and

(c) Attestation of having obtained required continuing education under OAR 331-415-0010, on a form prescribed by the Agency, whether license is current or inactive.

(4) INACTIVE LICENSE RENEWAL: A license may be inactive for up to three years. A licensee who is inactive is not authorized to practice. When renewing after entering inactive status, the licensee must submit the following:

(a) Renewal application form;

(b) Payment of delinquency and license fees pursuant to OAR 331-440-0000; and

(c) Attestation of having obtained required continuing education under OAR 331-415-0010, on a form prescribed by the Agency, whether license is current or inactive;

(5) EXPIRED LICENSE: A license that has been inactive for more than three years is expired and the licensee must reapply for licensure and meet the requirements listed in OAR 331-410-0035.

Stat. Auth.: ORS 676.605, 676.615, 680.525, 680.530 & 680.565
Stats. Implemented: ORS 676.605, 676.615, 680.525, 680.530 & 680.565
Hist.: HDLP 1-2002, f. 5-31-02, cert. ef 6-1-02; HLO 2-2004, f. 6-29-04, cert. ef. 7-1-04; HLA 10-2013, f. & cert. ef. 7-1-13

331-410-0080
Oral Pathology and Oral Health Certificate

(1) Denturists licensed prior to January 1, 2004, who have not received an oral pathology endorsement as described in ORS 680.545, may not treat any person without first obtaining a valid Oral Health Certificate for the person, signed by a licensed dentist, physician or nurse practitioner stating the person's oral cavity is substantially free from disease and mechanically sufficient to receive a denture. The examination of the oral cavity must have taken place within 30 days of the date of commencing treatment.

(2) For the purpose of this rule "Oral Pathology" means the precise study and diagnosis of disease including pathogenesis, morphologic changes and clinical manifestations of the mouth (the first portion of the alimentary canal that receives food and saliva).

Stat. Auth.: ORS 680.545
Stats. Implemented: ORS 680.545
Hist.: HD 12-1980(Temp), f. & ef. 9-29-80; HD 6-1981, f. & ef. 4-3-81; HD 4-1988, f. & cert. ef. 3-4-88; HD 4-1989, f. & cert. ef. 6-1-89; HD 3-1992, f. & cert. ef. 3-25-92; HD 22-1993, f. 12-30-93, cert. ef. 1-1-94; HDLP 3-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 333-020-0055; HDLP 1-2001, f. 3-21-01, cert. ef. 4-1-01; HLO 2-2004, f. 6-29-04, cert. ef. 7-1-04; HLA 10-2013, f. & cert. ef. 7-1-13

331-410-0090
License Display and Identification

(1) A licensee must show proof of valid license to the Agency upon request.

(2) A licensee may obtain up to a maximum of three duplicate licenses if the licensee provides denture technology services in multiple locations.

(3) A licensee must post the license document or duplicate license document in public view where denture technology services are being performed.

(4) A licensee may temporarily conceal the address printed on the license document with a covering that is removable.

Stat. Auth.: ORS 680.565
Stats. Implemented: ORS 680.565
Hist.: HD 12-1980(Temp), f. & ef. 9-29-80; HD 6-1981, f. & ef. 4-3-81; HD 22-1993, f. 12-30-93, cert. ef. 1-1-94; HD 22-1993, f. 12-30-93, cert. ef. 1-1-94; HDLP 3-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 333-020-0060; HLO 2-2004, f. 6-29-04, cert. ef. 7-1-04; HLA 10-2013, f. & cert. ef. 7-1-13

331-415-0010
Continuing Education Requirements

(1) To maintain licensure, a denturist must complete a minimum of 10 hours of continuing education every year.

(2) A licensee must document compliance with the continuing education requirement through attestation on the license renewal application. A licensee is subject to provisions of OAR 331-415-0020 pertaining to periodic audit of continuing education.

(3) Continuing education must be obtained by participation in or attendance at a course provided by an institution of higher education accredited by the Northwest Association of Accredited Schools, the Northwest Commission on Colleges and Universities, or the State Board of Higher Education, a course or program approved by the Oregon State Denturist Association, or the National Denturist Association, or other professional organizations or associations which conduct educational meetings, workshops, symposiums, and seminars where CEU credit is offered and where subject matter meets the requirements under subsection (4) of this rule.

(4) Continuing education must address subject matter related specifically to denture technology as set forth in ORS 680.515(1)(a), the rules regulating licensed denturists, related dental practices, health care professional concerns such as infection control or medical emergencies, ethics, and business practices.

(5) Continuing education may include teaching a course sponsored by a CE provider listed in subsection (3) of this rule and where the subject matter meets the requirements under subsection (4) of this rule (provided that no more than half the required hours be in teaching).

(6) Proof of participation in required continuing education is the responsibility of the denturist, to ensure that adequate proof of completion of required continuing education is available for audit or investigation by the Agency.

(7) Documentation supporting compliance with continuing education requirements must be maintained for a period of two years following renewal, and must be available to the Agency upon request.

(8) A licensee may carry up to 10 continuing education hours forward to the next renewal cycle.

(9) For the purpose of this rule continuing education hours mean actual academic, classroom, or course work time, including but not limited to workshops, symposiums, or seminars. Continuing education hours do not include travel time to or from the training site, registration or check-in periods, breaks or lunch periods.

Stat. Auth.: ORS 676.605, 680.530 & 680.565
Stats. Implemented: ORS 676.605, 680.530 & 680.565
Hist.: HD 10-1989, f. & cert. ef. 11-21-89; HD 13-1991 (Temp), f. & cert. ef. 9-30-91; HD 3-1992, f. & cert. ef. 3-25-92; HD 22-1993, f. 12-30-93, cert. ef. 1-1-94; HDLP 3-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 333-020-0041; HDLP 1-2001, f. 3-21-01, cert. ef. 4-1-01; HLO 2-2004, f. 6-29-04, cert. ef. 7-1-04; HLA 5-2008, f. 9-15-08, cert. ef. 10-1-08; HLA 10-2013, f. & cert. ef. 7-1-13

331-415-0020
Continuing Education: Audit, Required Documentation and Sanctions

(1) The Oregon Health Licensing Agency will audit a select percentage of licensee records determined by the Board to verify compliance with continuing education requirements.

(2) Licensees notified of selection for audit of continuing education attestation must submit to the Agency, within 30 calendar days from the date of issuance of the notification, satisfactory evidence of participation in required continuing education in accordance with OAR 331-415-0010.

(3) Successful completion of the required continuing education will be determined based on satisfactory evidence submitted to the Agency at the time of audit, which must include the following:

(a) Name of continuing education sponsor/provider;

(b) Course agenda — including the date of the training and breakdown of hours for each agenda item, lunch and breaks;

(c) Course outline — including a detailed summary of each topic discussed and the learning objective or training goal of each agenda item;

(d) Course content — including identification of the direct relationship between the course training and subject matter related to denture technology as set forth in ORS 680.515(1)(a) and OAR 331-415-0010(4);

(e) Background resume of speakers or instructors; and

(f) Documentation of attendance or successful course completion (eg, certificate, transcript, sponsor statement or affidavit attesting to attendance, diploma, etc).

(4) If documentation of continuing education is invalid or incomplete, the licensee has 30 calendar days from the date of the deficiency notice to correct the deficiency and submit further documentation to substantiate having completed the required continuing education.

(5) Misrepresentation of continuing education or failing to meet continuing education requirements or documentation may result in disciplinary action, which may include but is not limited to assessment of a civil penalty and suspension or revocation of the license.

Stat. Auth.: ORS 680.565
Stats. Implemented: ORS 680.565
Hist.: HDLP 3-1998, f. 6-26-98, cert. ef. 7-1-98; HDLP 1-2002, f. 5-31-02, cert. ef 6-1-02; HLO 2-2004, f. 6-29-04, cert. ef. 7-1-04; HLA 10-2013, f. & cert. ef. 7-1-13

331-420-0000
Practice Standards

Licensed denturists must adhere to the following practice standards:

(1) Oral Health Certificate. Denturists must either have an oral pathology endorsement on their license, or if they have not qualified for and received the endorsement, must comply with requirements for obtaining an Oral Health Certificate as described in ORS 680.545 and OAR 331-410-0080.

(2) Patient Record. A licensed denturist must record, update and maintain documentation for each patient relevant to health history, clinical examinations and treatment, and financial data. Documentation must be written or computerized. Records must include but are not limited to the following:

(a) Patient data, including name, address, date and description of examination;

(b) Evidence of informed consent (may be in the form of an acronym such as "PARQ" to denote procedure, alternatives, risks and questions);

(c) Date and description of treatment or services rendered, and any treatment complications;

(d) Health history as applicable; and

(e) Any other information deemed appropriate to patient care.

(3) Clinical Examination. Licensed denturists must conduct and record a clinical examination of each patient that will include at a minimum, information relative to:

(a) Appearance of gingiva, oral mucosal membranes, pharynx, tongue and all other oral soft tissue; and

(b) Oral conditions that may affect successful denture construction and use.

(4) Record Retention. Patient documentation, written or archived electronically by computer, must be retained for a minimum of seven years and available upon request by the Agency.

(5) Minimum Standards of Acceptable Patient Care. Licensees must adhere to the following practice standards in rendering acceptable patient care:

(a) Maintain accurate patient records;

(b) Seek consultation/referral if indicated;

(c) Make accurate representation to the patient on services provided;

(d) Provide or arrange for continuity of care or emergency treatment for a patient currently receiving treatment;

(e) Adhere to current denture technology practices and standards including use of materials;

(f) Adhere to Centers for Disease Control and Prevention infection control standards and practices;

(g) Wash hands using a germicidal or antiseptic soap and water before and after every patient;

(h) Wear disposable gloves when coming in direct contact with a patient or when handling instruments or equipment contaminated with blood or other potentially infectious materials.

(i) Use new gloves before performing procedures on each patient.

(6) A denturist providing teeth whitening trays to patients must provide the patient with written and verbal information related to teeth whitening trays and teeth whitening solutions including the procedure, alternatives, risks and questions which is prescribed by the Agency. The denturist must obtain patient consent for the procedure described in this rule and retain in patient record. The Agency prescribed information and informed consent for teeth whitening trays and solutions can be accessed on the Agency Website at http://www.oregon.gov/OHLA/DT/pages/index.aspx

(7) A denturist is prohibited from providing patients prescription strength teeth whitening solutions.

Stat. Auth.: ORS 676.605, 676.615, 680.550 & 680.565
Stats. Implemented: ORS 676.605, 676.615, 680.550 & 680.565
Hist.: HD 4-1988, f. & cert. ef. 3-4-88; HD 4-1989, f. & cert. ef. 6-1-89; HD 13-1991(Temp), f. & cert. ef. 9-30-91; HD 3-1992, f. & cert. ef. 3-25-92, Subsections (9)(a) through (h) renumbered to 333-020-0090 and 333-020-0100; HD 22-1993, f. 12-30-93, cert. ef. 1-1-94; HDLP 3-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 333-020-0085; HLO 1-2003, f. 1-21-03, cert. ef. 2-1-03; HLO 2-2004, f. 6-29-04, cert. ef. 7-1-04; HLA 10-2013, f. & cert. ef. 7-1-13

331-420-0010
Practice Standards for Business Premises

(1) A licensed denturist must:

(a) Ensure all areas of the business premises where denture technology is practiced are kept clean and in good repair;

(b) Have a sterilization area, where cleaning and sterilization of reusable instruments is performed, separated from public areas, service areas and restrooms;

(c) Maintain washing accommodations in a clean and sanitary condition;

(d) Ensure all floors, walls and procedure surfaces where services are provided including counters, tables, and chairs are easily cleanable, non-absorbent and non-porous;

(e) Ensure pets or other animals are not permitted in the business facility. This prohibition does not apply to service animals recognized by the American with Disabilities Act;

(f) Ensure all disinfecting solutions or agents be kept at adequate strengths according to manufacturer's instructions to maintain effectiveness, be free of foreign material and be available for immediate use at all times the business is open;

(g) Use equipment and instruments in a manner described in the manufacturer's instructions which is consistent with the manufacturer's intended use of the device by the FDA;

(h) Ensure chemicals are stored in labeled, closed containers;

(i) Ensure all waste material contaminated with blood or other potentially infectious materials, with exception of sharps, are deposited in a covered container following service for each patient; and

(j) Ensure all sharps are discarded in a sharps container which is a puncture-resistant, leak-proof container that can be closed for handling, storage, transportation, and disposal. The container must be labeled with the "Biohazard" symbol.

(2) The licensee must comply with all applicable rules and regulations of the Agency and other federal, state, county and local agencies. This includes the following:

(a) Building, fire, plumbing and electrical codes, and with exit and fire standards established by the Oregon Building Codes Division, and the Oregon Office of State Fire Marshal;

(b) Oregon Indoor Clean Air Act as it appears in ORS 433.835 through 433.875;

(c) Occupational Safety and Health Act Blood Borne Pathogens Standards, Universal Precautions and Exposure Control Plan under 29 CFR 1910.1030;

(d) Oregon Safe Employment Act pursuant to ORS Chapter 654 if an employee/employer relationship exists; and

(e) All applicable Occupational Safety and Health Act standards if an employee/employer relationship exists.

(f) All applicable recommendations from the Centers for Disease Control and Prevention.

(3) For the purpose of this rule "Sharps" means any object that can penetrate the skin, including but not limited to needles or scalpel blades.

(4) A licensee must ensure all procedures performed are done in a manner to avoid cross contamination of blood borne pathogens.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 680.550 & 680.565

Stats. Implemented: ORS 680.550 & 680.565

Hist.: HD 13-1991(Temp), f. & cert. ef. 9-30-91; HD 3-1992, f. & cert. ef. 3-25-92, Renumbered from 333-020-0085(9)(a) through (h); HD 22-1993, f. 12-30-93, cert. ef. 1-1-94; HDLP 3-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 333-020-0090; HLO 1-2003, f. 1-21-03 cert. ef. 2-1-03; HLA 10-2013, f. & cert. ef. 7-1-13

331-420-0020

Approved Sterilization and Disinfection Standards

(1) New gloves must be worn during any disinfection or sterilization procedure.

(2) The disinfection or sterilization process listed in subsection (4) or (5) of this rule is not required if disinfected or sterilized single-use prepackaged instruments, obtained from suppliers or manufacturers are used.

(3) All reusable instruments that come in direct contact with a client's skin or are exposed to blood or other potentially infectious materials must be disinfected or sterilized before use on a client or re-used on another client in accordance with subsection (4) or (5) of this rule.

(4) Approved cleaning and disinfection process for reusable instruments includes the following ordered method:

(a) Clean reusable instruments by manually brushing or swabbing visible foreign matter and rinsing the instruments with warm water and an appropriate detergent solution to remove blood and other potentially infectious materials;

(b) Immerse reusable instruments in a high level disinfectant defined under OAR 331-405-0020 and labeled accordingly; and

(c) Store disinfected instruments in a dry, disinfected, closed cabinet or other tightly-covered container reserved for the storage of disinfected instruments.

(5) Approved cleaning and sterilization process for reusable instruments includes the following ordered method:

(a) Clean reusable instruments by manually brushing or swabbing visible foreign matter and rinsing the instruments with warm water and an appropriate detergent solution to remove blood and other potentially infectious materials;

(b) Individually package reusable instruments using sterilization pouches that include a color indicator strip to assure sufficient temperature during each sterilization cycle. The date the sterilization was performed must be applied to the sterilization pouch;

(c) Place individually packaged reusable instruments in an autoclave sterilizer (steam or chemical), or dry heat sterilizer registered and listed with the Food and Drug Administration; and

(d) Store sterilized instruments individually packaged in a dry, disinfected, closed cabinet or other tightly-covered container reserved for the storage of sterilized instruments.

(6) As of July 1, 2014 all denturists are required to sterilize all reusable instruments by use of a dry heat or steam autoclave. All instruments that are not reusable and sterilized must be disposed of in an appropriate manner.

(7) If a denturist is using an autoclave or dry heat sterilizer under subsection (5) of this rule the denturist must have the autoclave or dry heat sterilizer biologically tested monthly (spore testing) verified through an independent laboratory, to assure all microorganisms have been destroyed and sterilization achieved. Biological spore test results must be immediately available at all times for inspection by the Agency and kept at facility premises for a minimum of two years.

(8) If a denturist is using an autoclave or dry heat sterilizer under subsection (5) of this rule they must ensure the entire device is cleaned and maintained in accordance with manufacturer's instructions and a copy of the manufacturer's recommended procedures for the operation of the device must be kept on file at the business premise.

(9) The expiration date for sterilized reusable instruments under subsection (5) of this rule is one year from the date of sterilization unless the integrity of the package is compromised.

(10) All surfaces that may be contaminated by blood or other potentially infectious materials must be disinfected with a high-level disinfectant defined under OAR 331-405-0020 and is labeled accordingly.

Stat. Auth.: ORS 676.605, 676.615, 680.550 & 680.565

Stats. Implemented: ORS 676.605, 676.615, 680.550 & 680.565

Hist.: HD 3-1992, f. & cert. ef. 3-25-92, Renumbered from 333-020-0085(9)(a) through (h); HD 22-1993, f. 12-30-93, cert. ef. 1-1-94; HDLP 3-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 333-020-0100; HDLP 1-2001, f. 3-21-01, cert. ef. 4-1-01; HLO 1-2003, f. 1-21-03, cert. ef. 2-1-03; HLO 2-2004, f. 6-29-04, cert. ef. 7-1-04; HLA 10-2013, f. & cert. ef. 7-1-13

331-430-0030

Establishing Civil Penalty Amounts

The Oregon Health Licensing Agency has adopted the following presumptive penalty schedule for the first and second violations of the following laws and rules. The following schedule must apply except as the Agency otherwise determines in consideration of the factors referenced in OAR 331-020-0060. For subsequent violations the provisions of OAR 331-020-0060 will apply.

(1) Practicing or holding one's self out as available to practice denture technology, or using the title denturist without a license or with an expired or suspended license is a violation of ORS 680.505 and may incur a penalty of $5,000.

(2) Licensed denturists who allow non-licensed persons to violate ORS 680.505 are in violation of and ORS 676.612(i) and may incur a penalty of $5,000.

(3) Violations of ORS 680.545 may incur a penalty of $2000.

(4) Failing to notify the Agency within 30 days of a change in business related information or license status is a violation of OAR 331-010-0040, and may incur a penalty of $200.

(5) Advertising in a manner, which would deceive or mislead the public or that is untruthful is a violation of ORS 676.612(2)(b), and may incur a penalty of $2,000.

(6) Violations of the practice standards in Division 420 may incur a penalty of up to $1,000 for each violation.

(7) Failing to meet minimum standards of acceptable patient care according to OAR 331-420-0000(5), as determined by the board may incur a penalty of $5,000.

Stat. Auth.: ORS 680.565 & 680.572

Stats. Implemented: ORS 680.565 & 680.572

Hist.: HD 3-1992, f. & cert. ef. 3-25-92; HD 22-1993, f. 12-30-93, cert. ef. 1-1-94; HDLP 3-1998, f. 6-26-98, cert. ef. 7-1-98, Renumbered from 333-020-0120; HDLP 1-2001, f. 3-21-01, cert. ef. 4-1-01; HLO 2-2004, f. 6-29-04, cert. ef. 7-1-04; HLA 10-2013, f. & cert. ef. 7-1-13

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Rules Amended: 331-905-0000, 331-905-0005, 331-905-0010, 331-905-0040, 331-905-0050, 331-905-0080
Rules Repealed: 331-905-0070
Subject: The rule revision amends specialty level 1 genital piercing education and training to remove the requirement of 10 hours of theory. The rule retains the requirement of 36 hours of practical education or training including practical operations where the student or trainee observes 6 practical operations, participates in 10 practical operations and performs 20 practical operations under direct supervision. The school or approved supervisor is required to submit documentation to the Agency showing proof of having performed the 36 practical operations.

The change amends specialty level 2 genital piercing education and training to remove the requirement of 5 hours of theory. The rule retains the requirement of 26 hours of practical education or training including practical operations where the student or trainee observes 6 practical operations, participates in 10 practical operations and performs 10 practical operations under direct supervision. The school or approved supervisor is required to submit documentation to the Agency showing proof of having performed the 26 practical operations.

The rule removes the requirement of taking a written examination regarding genital piercing for both specialty level 1 and 2 genital piercing. The proposal requires that if the written standard body piercing examination is not passed within 2 years of application for a specialist level 1 or 2 genital piercing license the applicant would have to take and pass the examination again.

Repeal rule related to approved specialty body piercing examinations and amend retake requirements to align with standard body piercing
Rules Coordinator: Samantha Patnode—(503) 373-1917

331-905-0000
Specialty Body Piercing Definitions

The following definitions apply to OAR chapter 331, division 900:

(1) "Affidavit of Licensure" has the meaning set forth in OAR 331-030-0040.

(2) "Agency" means the Oregon Health Licensing Agency.

(3) "APP" means Association of Professional Piercers.

(4) "Body piercing" has the definition set forth in ORS 690.350.

(5) "Direct supervision" means the supervisor or instructor is present in the facility and actively involved in direct oversight and training of students.

(6) "EPA" means United States Environmental Protection Agency.

(7) "FDA" means Food and Drug Administration.

(8) "Field of practice" has the definition set forth in ORS 690.350.

(9) "High-level disinfectant" means a chemical agent, registered with the EPA, which has demonstrated tuberculocidal activity.

(10) "Instruments" means equipment used during body piercing services. Types of instruments include but are not limited to needles, forceps, hemostats, tweezers, and jewelry.

(11) "Official transcript" means:

(a) An original document authorized by the appropriate office in the Oregon Department of Education and certified by an educational institution indicating applicant identity information, field of practice(s) enrolled under, specific hour requirements for each field of practice if applicable, final practical examination scores for each field of practice, enrollment information and a signature by an authorized representative on file with the agency. Original documents must be submitted directly to the agency from the educational institution by United States Postal Service mail or other recognized mail service providers in a sealed envelope;

(12) "Practitioner" means a person licensed to perform services included within a field of practice.

(13) "Sharps container" means a puncture-resistant, leak-proof container that can be closed for handling, storage, transportation, and disposal. The container must be labeled with the "Biohazard" symbol.

(14) "Specialty level one genital piercing" includes the following:

(a) Male genital piercings including the scrotum, frenum, foreskin, or the perineum behind the scrotum, and the piercing of the penis through the urethra, perineum behind the scrotum (Guiche) and exiting on the underside of the penis (called a "Prince Albert"); and

(b) Female genital piercing including the labia majora, labia minors, piercings of the clitoral hood, and perineum between the vagina and the anus (fourchette).

(15) "Specialty level two genital piercing" includes the following:

(a) Male genital piercings including: a vertical piercing through the glans of the penis (called an "apadravya"), horizontal piercing through the glans of the penis (called an "ampallang"), a piercing through the corona or ridge of the glans of the penis (called a "dydoe"), a piercing of the penis entering through the urethra and exiting on the upper side of the penis (called a "reverse Prince Albert"); and

(b) Female genital piercings including the clitoris, a piercing in which jewelry is inserted below the hood behind the clitoris (called a "triangle"), and a piercing of the vagina through the urethra and exiting on the upper side of the vagina (called a "Princess Albertina").

Stat. Auth.: ORS 676.607,676.615, 676.625, 690.365, 690.371, 690.385, 690.390, 690.405, 690.407, 690.410, 690.415, & 345
Stats. Implemented: ORS 676.607,676.615, 676.625, 690.365, 690.371, 690.385, 690.390, 690.405, 690.407, 690.410, 690.415, OL 2011, Ch. 346, Sec. 22 & 35
Hist.: HLA 14-2011(Temp), f. 12-30-11, cert. ef. 1-1-12 thru 6-25-12; HLA 3-2012(Temp), f. & cert. ef. 3-1-12 thru 6-25-12; HLA 10-2012, f. & cert. ef. 6-25-12; HLA 1-2013, f. & cert. ef. 1-16-13; HLA 6-2013(Temp), f. 3-20-13, cert. ef. 4-1-13 thru 9-28-13; HLA 11-2013, f. & cert. ef. 7-1-13

331-905-0005
Specialty Level One Genital Piercing Education or Training

Beginning on January 1, 2013, all education curriculum or training for specialty level one genital piercing must meet requirements set forth by the Oregon Health Licensing Agency prior to beginning training or education.

(1) Education Requirements for Specialty Level One Genital Piercing Student: An individual must obtain a standard body piercing license prior to beginning education for specialty level one genital piercing. The specialty level one genital piercing career school course of study must include 36 hours of practical education and a minimum of 36 practical operations.

(2) The 36 practical operations required must include:

(a) 6 practical operations observed by the student which must include a minimum of 3 female genital piercings and a minimum of 3 male genital piercings. Out of the 6 practical operations the student must observe at least 4 different piercing procedures listed in subsection (3) of this rule;

(b) 10 practical operations in which the student participated which must include a minimum of 3 female genital piercings and a minimum of 3 male genital piercings. Out of the 10 practical operations the student must participate in at least 4 different piercing procedures listed in subsection (3) of this rule; and

(c) 20 practical operations performed by the student under direct supervision, but without assistance which must include a minimum of 6 female genital piercings and a minimum of 6 male genital piercings. Out of the 20 practical operations the student must perform at least 4 different piercing procedures listed in subsection (3) of this rule.

(3) The 36 piercings included in the practical training must include at least 3 different piercing procedures listed in Subsection (a) through (i) below of this rule:

(a) Scrotum;

(b) Frenum;

(c) Foreskin;

(d) Perineum behind the scrotum (Guiche);

(e) Piercing of the penis through the urethra and exiting on the underside of the penis (Prince Albert);

(f) Labia majora;

(g) Labia minora;

(h) Piercing of the perineum between the vagina and the anus (fourchette); and

(i) Piercing of the clitoral hood.

(4) Education must be conducted by a Department of Education, Private Career School licensed instructor who holds an active specialty level one genital piercing license.

(5) A Department of Education, Private Career School licensed instructor must provide direct supervision of practical training on a one-to-one student/teacher ratio for students performing practical training while working on the general public.

(6) Supervised Training Requirements for Specialty Level One Genital Piercing Temporary Trainee: An individual must obtain a standard body piercing license prior to beginning training for specialty level one genital piercing. The specialty level one genital piercing training program must include 46 36 hours of practical training and a minimum of 36 practical operations.

(7) The 36 practical operations required must include:

(a) 6 practical operations observed by the trainee which must include a minimum of 3 female genital piercings and a minimum of 3 male genital piercings. Out of the 6 practical operations the trainee must observe at least 4 different piercing procedures listed in subsection (8) of this rule;

(b) 10 practical operations in which the trainee participated which must include a minimum of 3 female genital piercings and a minimum of 3 male genital piercings. Out of the 10 practical operations the trainee must participate in at least 4 different piercing procedures listed in subsection (8) of this rule; and

(c) 20 practical operations performed by the trainee under direct supervision, but without assistance which must include a minimum of 3 female genital piercings and a minimum of 3 male genital piercings. Out of the 20 practical operations the trainee must perform at least 3 different piercing procedures listed in subsection (8) of this rule.

(8) The 36 piercings included in the practical training must include at least 3 different piercing procedures listed below in subsection (a) through (i) below of this rule:

(a) Scrotum;

(b) Frenum;

(c) Foreskin;

(d) Perineum behind the scrotum (Guiche);

(e) Piercing of the penis through the urethra and exiting on the underside of the penis (Prince Albert);

(f) Labia majora;

(g) Labia minora;

(h) Piercing of the perineum between the vagina and the anus (fourchette); and

(i) Piercing of the clitoral hood.

(9) Training must be completed in no less than two months from the date the Agency issues a specialty level one genital piercing temporary trainee license.

(10) A supervisor must provide direct supervision of practical training on a one-to-one trainee to trainer ratio for trainees performing practical training while the trainee is working on the general public.

Stat. Auth.: ORS 676.607,676.615, 676.625, 690.365, 690.371, 690.385, 690.390, 690.405, 690.407, 690.410, 690.415, & 345

Stats. Implemented: ORS 676.607,676.615, 676.625, 690.365, 690.371, 690.385, 690.390, 690.405, 690.407, 690.410, 690.415, OL 2011, Ch. 346, Sec. 22 & 35
Hist.: HLA 14-2011(Temp), f. 12-30-11, cert. ef. 1-1-12 thru 6-25-12; HLA 3-2012(Temp), f. & cert. ef. 3-1-12 thru 6-25-12; HLA 10-2012, f. & cert. ef. 6-25-12; HLA 1-2013, f. & cert. ef. 1-16-13; HLA 6-2013(Temp), f. 3-20-13, cert. ef. 4-1-13 thru 9-28-13; HLA 11-2013, f. & cert. ef. 7-1-13

331-905-0010
Specialty Level Two Genital Piercing Education or Training

Beginning on January 1, 2013, all education curriculum or training for specialty level two genital piercing must meet requirements set forth by the Oregon Health Licensing Agency prior to beginning training or education.

(1) Education Requirements for Specialty Level Two Genital Piercing Student: An individual must obtain a standard body and specialty level one genital piercing license prior to beginning education for specialty level two genital piercing. The specialty level two genital piercing career school course of study must include 26 hours of practical education and a minimum of 26 practical operations. (2) The 26 practical operations required must include:

(a) 6 practical operations observed by the student. Out of the 6 practical operations the student must observe at least 3 different piercing procedures listed in subsection (5) (3) of this rule;

(b) 10 practical operations in which the student participated. Out of the 10 practical operations the student must participate in at least 3 different piercing procedures listed in subsection (3) of this rule; and

(c) 10 practical operations performed by the student under direct supervision, but without assistance. Out of the 10 practical operations the student must perform at least 3 different piercing procedures listed in subsection (3) of this rule.

(3) The 26 piercings included in the practical training must include at least 3 different piercing procedures listed in Subsection (a) through (h) of this rule:

(a) Piercing of the penis entering through the urethra and exiting on the upper side of the penis (reverse Prince Albert);

(b) Piercing through the corona or ridge of the glans of the penis (dydoe);

(c) Horizontal piercing through the glans of the penis (ampallang);

(d) Vertical piercing through the glans of the penis (apadravya);

(e) Clitoris;

(f) Piercing in which jewelry is inserted below the hood behind the clitoris (triangle);

(g) Any piercing of the female genitals through the urethra; and

(h) Any other genital piercings not listed in specialty level one genital piercing.

(4) As part of the approved course of study, all hours of theory must be completed prior to practical work being performed.

(5) Education must be conducted by a Department of Education, Private Career School licensed instructor who holds an active specialty level two genital piercing license.

(6) A Department of Education, Private Career School licensed instructor must provide direct supervision of practical training on a one-to-one student/teacher ratio for students performing practical training while working on the general public.

(7) Supervised Training Requirements for Specialty Level Two Genital Piercing Temporary Trainee: An individual must obtain a standard body and specialty level one genital piercing license prior to beginning training for specialty level two genital piercing. The specialty level two genital piercing training program must include 26 hours of practical training and a minimum of 26 practical operations. The training must include a minimum of

(8) The 26 practical operations required must include:

(a) 6 practical operations observed by the trainee. Out of the 6 practical operations the trainee must observe at least 3 different piercing procedures listed in subsection (9) of this rule;

(b) 10 practical operations in which the trainee participated. Out of the 10 practical operations the trainee must participate in at least 3 different piercing procedures listed in subsection (9) of this rule; and

(c) 10 practical operations performed by the trainee under direct supervision, but without assistance. Out of the 10 practical operations the trainee must perform at least 3 different piercing procedures listed in subsection (9) of this rule.

(9) The 26 piercings included in the practical training must include at least three different piercing procedures listed in Subsection (a) through (h) of this rule:

(a) Piercing of the penis entering through the urethra and exiting on the upper side of the penis (reverse Prince Albert);

(b) Piercing through the corona or ridge of the glans of the penis (dydoe);

(c) Horizontal piercing through the glans of the penis (ampallang);

(d) Vertical piercing through the glans of the penis (apadravya);

(e) Clitoris;

(f) Piercing in which jewelry is inserted below the hood behind the clitoris (triangle);

(g) Any piercing of the female genitals through the urethra; and

(h) Any other genital piercings not listed in specialty level one genital piercing.

(10) Training must be completed in no less than 2 months from the date the Agency issues a specialty level two genital piercing temporary trainee license.

(11) A supervisor must provide direct supervision of practical training on a one-to-one trainee to trainer ratio for trainees performing practical training while the trainee is working on the general public.

Stat. Auth.: ORS 676.607,676.615, 676.625, 690.365, 690.371, 690.385, 690.390, 690.405, 690.407, 690.410, 690.415, & 345
Stats. Implemented: ORS 676.607,676.615, 676.625, 690.365, 690.371, 690.385, 690.390, 690.405, 690.407, 690.410, 690.415, OL 2011, Ch. 346, Sec. 22 & 35
Hist.: HLA 14-2011(Temp), f. 12-30-11, cert. ef. 1-1-12 thru 6-25-12; HLA 3-2012(Temp), f. & cert. ef. 3-1-12 thru 6-25-12; HLA 10-2012, f. & cert. ef. 6-25-12; HLA 1-2013, f. & cert. ef. 1-16-13; HLA 6-2013(Temp), f. 3-20-13, cert. ef. 4-1-13 thru 9-28-13; HLA 11-2013, f. & cert. ef. 7-1-13

331-905-0040
Application Requirements for Specialty Level One Genital Piercing License

(1) An individual applying for licensure to practice specialty level one genital piercing must:

(a) Meet the requirements of OAR 331 division 30;

(b) Submit a completed application form prescribed by the Agency, which must contain the information listed in OAR 331-030-0000 and be accompanied by payment of the required application fees;

(c) Submit proof of current cardiopulmonary resuscitation and basic first aid training from an Agency approved provider;

(d) Submit proof of current blood borne pathogens training from an Agency approved provider;

(e) Submit proof of being 18 years of age documentation may include identification listed under OAR 331-030-0000;

(f) Submit proof of having a high school diploma or equivalent; and

(g) Provide documentation of completing a qualifying pathway.

(2) License Pathway 1 — Graduate from an Oregon Licensed Career School for Specialty Level One Genital Piercing must:

(a) Submit official transcript from a specialty level one genital piercing career school under ORS 345 showing proof of completion of required specialty level one genital piercing curriculum as approved by the Agency under OAR 331-905-0005 (1) through (5);

(b) If applicable, pay examination fees;

(c) Submit passing score of the Agency approved standard body piercing written examinations in accordance with OAR 331-900-0060 (2) and (3). Completion of the written examination is not required if the applicant has passed the examinations listed under OAR 331-900-0060 (2) and (3) within two years before the date of application; and

(d) Upon passage of all required examinations, if applicable, and before issuance of license, applicant must pay all license fees.

(3) License Pathway 2 — Qualification through Specialty Level One Genital Piercing Temporary Trainee License:

(a) Submit documentation approved by the Agency showing proof of having completed required specialty level one genital training listed under OAR 331-905-0005 (6) through (10), and verified by a supervisor approved under OAR 331-905-0055, on a form prescribed by the Agency;

(b) If applicable, pay examination fees;

(c) Submit passing score of the Agency approved standard body piercing written examinations in accordance with OAR 331-900-0060 (2) and (3). Completion of the written examination is not required if the applicant has passed the examinations listed under OAR 331-900-0060 (2) and (3) within two years before the date of application; and

(d) Upon passage of all required examinations, if applicable, and before issuance of license, applicant must pay all license fees.

Stat. Auth.: ORS 676.607,676.615, 676.625, 690.365, 690.371, 690.385, 690.390, 690.405, 690.407, 690.410, 690.415, & 345
Stats. Implemented: ORS 676.607,676.615, 676.625, 690.365, 690.371, 690.385, 690.390, 690.405, 690.407, 690.410, 690.415, OL 2011, Ch. 346, Sec. 22 & 35
Hist.: HLA 14-2011(Temp), f. 12-30-11, cert. ef. 1-1-12 thru 6-25-12; HLA 3-2012(Temp), f. & cert. ef. 3-1-12 thru 6-25-12; HLA 10-2012, f. & cert. ef. 6-25-12; HLA 1-2013, f. & cert. ef. 1-16-13; HLA 6-2013(Temp), f. 3-20-13, cert. ef. 4-1-13 thru 9-28-13; HLA 11-2013, f. & cert. ef. 7-1-13

331-905-0050
Application Requirements for Specialty Level Two Genital Piercing License

(1) An individual applying for licensure to practice specialty level two genital piercing must:

(a) Meet the requirements of OAR 331 division 30;

(b) Submit a completed application form prescribed by the Agency, which must contain the information listed in OAR 331-030-0000 and be accompanied by payment of the required application fees;

(c) Submit proof of current cardiopulmonary resuscitation and basic first aid training from an Agency approved provider;

(d) Submit proof of current blood borne pathogens training from an Agency approved provider;

(e) Submit proof of being 18 years of age documentation may include identification listed under OAR 331-030-0000;

(f) Submit proof of having a high school diploma or equivalent; and

(g) Provide documentation of completing a qualifying pathway;

(2) License Pathway 1 — Graduate from an Oregon Licensed Career School for Specialty Level Two Genital Piercing:

(a) Submit official transcript from a specialty level two genital piercing career school under ORS 345 and showing proof of completion of required specialty level two genital piercing curriculum as approved by the Agency under OAR 331-905-0010 (1) through (6);

(b) If applicable, Pay pay examination fees;

(c) Submit passing score of the Agency approved standard body piercing written examinations in accordance with OAR 331-900-0060(2) and (3). Completion of the written examination is not required if the applicant has passed the examinations listed under OAR 331-900-0060(2) and (3) within two years before the date of application; and

(d) Upon passage of all required examinations, if applicable, and before issuance of license, applicant must pay all license fees.

(3) License Pathway 2 — Qualification through Specialty Level Two Genital Piercing Temporary Trainee License:

(a) Submit documentation approved by the Agency showing proof of having completed required specialty level two genital training listed under OAR 331-905-0010 (7) through (11), verified by a supervisor approved under OAR 331-905-0060 on a form prescribed by the Agency;

(b) If applicable, pay examination fees;

(c) Submit passing score of the Agency approved standard body piercing written examinations in accordance with OAR 331-900-0060(2) and (3). Completion of the written examination is not required if the applicant has passed the examinations listed under OAR 331-900-0060(2) and (3) within two years before the date of application; and

(d) Upon passage of all required examinations, if applicable, and before issuance of license, applicant must pay all license fees.

Stat. Auth.: ORS 676.607,676.615, 676.625, 690.365, 690.371, 690.385, 690.390, 690.405, 690.407, 690.410, 690.415, & 345
Stats. Implemented: ORS 676.607,676.615, 676.625, 690.365, 690.371, 690.385, 690.390, 690.405, 690.407, 690.410, 690.415, OL 2011, Ch. 346, Sec. 22 & 35
Hist.: HLA 14-2011(Temp), f. 12-30-11, cert. ef. 1-1-12 thru 6-25-12; HLA 3-2012(Temp), f. & cert. ef. 3-1-12 thru 6-25-12; HLA 10-2012, f. & cert. ef. 6-25-12; HLA 1-2013, f. & cert. ef. 1-16-13; HLA 6-2013(Temp), f. 3-20-13, cert. ef. 4-1-13 thru 9-28-13; HLA 11-2013, f. & cert. ef. 7-1-13

331-905-0080
Written Examination Retake Requirements

Individuals failing the written examination must meet the requirements listed under OAR 331-900-0070 before taking the examination a subsequent time.

Stat. Auth.: ORS 676.607,676.615, 676.625, 690.365, 690.371, 690.385, 690.390, 690.405, 690.407, 690.410, 690.415, & 345
Stats. Implemented: ORS 676.607,676.615, 676.625, 690.365, 690.371, 690.385, 690.390, 690.405, 690.407, 690.410, 690.415, OL 2011, Ch. 346, Sec. 22 & 35
Hist.: HLA 10-2012, f. & cert. ef. 6-25-12; HLA 1-2013, f. & cert. ef. 1-16-13; HLA 6-2013(Temp), f. 3-20-13, cert. ef. 4-1-13 thru 9-28-13; HLA 11-2013, f. & cert. ef. 7-1-13

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Rule Caption: Removes temporary discounts from the Board of Body Art fee structure, 331-940-0000.
Adm. Order No.: HLA 12-2013
Filed with Sec. of State: 7-3-2013
Certified to be Effective: 7-9-13
Notice Publication Date: 6-1-2013
Rules Amended: 331-940-0000
Subject: The Oregon Health Licensing Agency significantly reduced the Board of Body Art Practitioners ending balance as discussed with the Board, the Department of Administrative Services, and the Legislative Fiscal Office. Since March 5, 2012 the Board of Body Art Practitioner's has waived body piercing written and practical exams, facility applications, original facility licenses and renewals and practitioner renewal fees for licenses issued prior to January 1, 2012. Discounts expire on June 30, 2013.
Rules Coordinator: Samantha Patnode—(503) 373-1917

331-940-0000
Fees

(1) Applicants and licensees are subject to the provisions of OAR 331-010-0010 and 331-010-0020 regarding the payment of fees, penalties and charges.

(2) Fees established by the Oregon Health Licensing Agency are as follows:

(a) Application:
(A) Standard Body Piercing — $50.
(B) Specialty Body Piercing Level 1 — $50.
(C) Specialty Body Piercing Level 2 — $50.
(D) Electrology — $50.
(E) Tattoo — $50.
(F) Reciprocity Per Field of Practice — $150.
(G) Facility — $100.
(H) Mobile Facility — $100.
(I) Event Facility — $100.
(J) Temporary Facility License — $100.
(K) Temporary Practitioner Per Field of Practice — $50.
(L) Standard Body Piercing Trainee — $50.
(M) Ear Lobe Piercing Temporary — $25.
(b) Examination:
(A) Written — $50.
(B) Practical — $100.
(c) Original Issuance of License:
(A) Standard Body Piercing Trainee — $50.
(B) Standard Body Piercing — $50.
(C) Specialty Body Piercing Level 1 — $50.
(D) Specialty Body Piercing Level 2 — $50.
(E) Electrology — $25.
(F) Tattoo — $50.
(G) License for a Field of Practice by Reciprocity — $50.
(H) Facility — $150.
(I) Mobile Facility — $150.
(J) Event Facility:
(i) Up to 100 booths: $725.
(ii) 101 to 200 booths: $1,450.
(iii) 201 to 300 booths: $2,175.
(iv) 301 to 400 booths: $2,900.
(v) 401 to 500 booths: $3,625.
(K) Temporary Practitioner Per Field of Practice — $20.
(L) Temporary Facility — $50.
(M) Earlobe Piercing Temporary — $25.
(d) Renewal of License Online:
(A) Standard Body Piercing — $45.
(B) Electrology — $20.
(C) Tattoo — $45.
(D) Temporary Earlobe — $20.
(E) Body Art Facility — $125.
(F) Mobile Facility License — $125.
(e) Renewal of License Over-the-Counter or Through the Mail:
(A) Standard Body Piercing Trainee — $50.
(B) Standard Body Piercing — $50.
(C) Specialty Body Piercing Level 1 — $50.
(D) Specialty Body Piercing Level 2 — $50.
(E) Electrology — $25.
(F) Tattoo — $50.
(G) Temporary Earlobe — $25.
(H) Temporary Practitioner Per Field of Practice — $20.
(I) Body Art Facility — $150.
(J) Mobile Facility License — $150.
(f) Other administrative fees:
(A) Delinquency — $50 per year, up to three years.
(B) Replacement License — $25.
(C) Duplicate License — $25 per copy with maximum of three.
(D) Affidavit of Licensure — $50.
(E) Information Packets — $10.
(F) Administrative Processing Fee — $25.

Stat. Auth: ORS 345, 676.607, 676.615, 676.625, 690.365, 690.370, 690.385, 690.390, 690, 405, 690.407, 690.410 & 690.415

Stats. Implemented: ORS 676.607, 676.608, 676.612, 676.615, 676.625, 690.350, 690.360, 690.365, 690.370, 690.380, 390.385, 690.390, 690.405, 690.407, 690.410, 690.415 & 2011 OL Ch. 346 § 22 & 35
Hist.: HLA 16-2011, f. 12-30-11, cert. ef. 1-1-12; HLA 4-2012(Temp), f. & cert. ef. 3-5-12 thru 9-1-12; HLA 11-2012, f. & cert. ef. 7-25-12; HLA 8-2013(Temp), f. 6-7-13, cert. ef. 7-1-13 thru 7-8-13; HLA 12-2013, f. 7-3-13, & cert. ef. 7-9-13

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Oregon Health Licensing Agency, Board of Direct Entry Midwifery Chapter 332

Rule Caption: Align continuing education requirements with law regarding additional hours as a requirement for renewal.
Adm. Order No.: DEM 1-2013(Temp)
Filed with Sec. of State: 7-10-2013
Certified to be Effective: 7-12-13 thru 1-8-14
Notice Publication Date:
Rules Amended: 332-020-0010
Subject: Amend continuing education rule to align with the intent and scope of the law. Require that at the time of renewal a licensed direct entry midwife (LDM) provide the number of births performed during the previous renewal cycle. If that number is fewer than five, then the LDM would be required to attest to 10 additional continuing education hours during the next renewal cycle. See example below:

LDM becomes inactive on July 31, 2013 on the renewal the LDM shows that during the previous renewal cycle July 2012 through July 2013 only three births were performed. When the LDM renews the license which becomes inactive on July 31, 2014 they will be required to attest to an additional 10 hours of continuing education.

A letter will be mailed by the agency to the LDM notifying them they will be required to attest to the 10 additional hours of continuing education.
Rules Coordinator: Samantha Patnode—(503) 373-1917

332-020-0010
Continuing Education

(1)(a) HOURLY REQUIREMENTS: To qualify for license renewal an LDM must complete approved continuing education requirements as follows:

(b) Two years from the date of initial licensure and every two years thereafter:

(A) Thirty clock hours relevant to women's health, neonatal, fetal or midwifery knowledge or care, ethics, communication, or professional development.

(B) Eight and a half clock hours pertaining to legend drugs and devices that include the components listed under OAR 332-015-0070 with the exception of neonatal resuscitation under 332-015-0070(e), which is required annually upon renewal. The eight and a half hours pertaining to legend drugs and devices must be taught by a MEAC accredited or pre-accredited school, the Oregon Midwifery Council or by an organization authorized by the board.

(i) One hour in pharmacology;

(ii) One half hour in administration of medications through injection;

(iii) One hour in advanced treatment of shock;

(iv) Three hours in intravenous therapy; and

(v) Three hours in suturing.

(2) CONTINUING EDUCATION PROVIDERS/SPONSORS: Continuing education includes attendance or participation at an instructional program presented, recognized, or under the auspices of any board approved institution or professional organization or association:.

(3) CONTINUING EDUCATION PATHWAYS:

(a) Attendance at lectures, post-secondary school or postgraduate courses, scientific sessions at conventions, courses offered by an agency or board approved association or licensed/accredited school, classes or courses offered through an institution such as the American Red Cross, hospitals, health care clinics, correspondence courses or internet courses.

(b) Continuing education relating to subject matter listed in subsection (1)(a)(A) of this rule may also be obtained through research or teaching (provided that no more than half the required hours be in teaching).

(c) Up to nine clock hours of continuing education relating to subject matter listed in subsection (1)(a)(A) of this rule may be completed through self-study and documented on forms provided by the agency.

(4) DOCUMENTATION REQUIREMENTS: Submission to the agency of proof of participation in continuing education is the responsibility of the LDM. The following provisions specify requirements for documenting completion of continuing education:

(a) Documentation must include the name of the sponsoring institution, association or organization, title of presentation, description of content, name of instructor or presenter, date, duration in hours, and license or statement of attendance or completion provided by the sponsor.

(b) Documentation verifying completion of all required continuing education must be accumulated and held by the LDM for two years following any reporting period, or until notification of audit is received. Continuing education documentation must be available and provided to the agency upon request. Refer to OAR 332-020-00105.

(5) ADDITIONAL REQUIREMENTS AND PROVISIONS: In addition to other requirements specified in this rule section, the following provisions apply toward meeting continuing education requirements as a condition of license renewal:

(a) In accordance with ORS 687.425 a licensee who has attended fewer than ten births in the previous year is required to take an additional ten hours of continuing education in subjects listed in subsection (1)(a)(A) of this rule during the next renewal cycle.

(b) Hours of continuing education that are obtained in excess of the minimum requirements listed in this rule will not be carried forward as credit for the subsequent license renewal reporting cycle.

(c) Continuing education is required for renewal even if the LDM license has been inactive, revoked or suspended during that period.

Stat. Auth.: ORS 676.615, 687.425 & 687.485
Stats. Implemented: ORS 676.615, 687.425 & 687.485
Hist.: DEM 1-1993(Temp), f. & cert. ef. 12-22-93; DEM 1-1994, f. & cert. ef. 6-15-94; DEM 1-2001(Temp), f. & cert. ef. 10-1-01 thru 3-29-02; DEM 1-2002, f. 2-25-02 cert. ef. 3-1-02; DEM 1-2004, f. 6-29-04, cert. ef. 7-1-04; DEM 2-2008(Temp), f. 9-15-08 cert. ef. 10-1-08 thru 3-30-09; DEM 1-2009, f. 3-31-09, cert. ef. 4-1-09; DEM 5-2010, f. 12-30-10, cert. ef. 1-1-11; DEM 1-2013(Temp), f. 7-10-13, cert. ef. 7-12-13 thru 1-8-14

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Oregon Housing and Community Services Department Chapter 813

Rule Caption: Renumbers rules to improve readability for participants of Low Income Housing Tax Credit Program
Adm. Order No.: OHCS 5-2013
Filed with Sec. of State: 6-21-2013
Certified to be Effective: 6-21-13
Notice Publication Date:
Rules Renumbered: 813-090-0030 to 813-090-0037, 813-090-0029 to 813-090-0039, 813-090-0025 to 813-090-0067, 813-090-0060 to 813-090-0080, 813-090-0070 to 813-090-0095
Subject: The Low-Income Housing Tax Credit Program assists and encourages the development of affordable multifamily housing development rental units through the allocation of housing tax credits.
Rules Coordinator: Sandy McDonnell—(503) 986-2012

813-090-0037
Qualified Allocation Plan and Project Evaluation

(1) The Department shall develop and maintain a qualified allocation plan for the allocation of Housing Credit.

(2) The Department may periodically solicit applications or select projects from a pool of qualified applications for the allocation of Housing Credit pursuant to the Department's qualified allocation plan. Applications will be evaluated consistent with IRC Section 42, ORS 456.559(1)(f), the rules of this division and procedures consistent with the Department goals to provide long term affordable housing.

[Publications: Publications referenced are available from the agency.
Stat. Auth.: ORS 456.515 - 456.720
Stats. Implemented: ORS 456.559(1)(f)
Hist. HSG 12-1990(Temp), f. & cert. ef. 5-29-90; HSG 14-1990, f. & cert. ef. 10-26-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 7-1991, f. & cert. ef. 12-19-91; Renumbered from 813-090-0030, OHCS 5-2013, f. & cert. ef. 6-21-13

813-090-0039
Extended Use Period Low-Income Commitment

(1) No allocation shall be made by the Department to an Applicant until or unless the Department and the Applicant enter into a Reservation and Extended Use Agreement. The Reservation and Extended Use Agreement shall specify, among other things, a minimum applicable unit fraction as defined by IRC Section 42(c)(1) (B) and the rent formula to be maintained for the Project to continue to qualify for Housing Credit.

(2) An executed Reservation and Extended Use Agreement shall be enforceable in any State court by any individual who qualified for occu-

pancy by virtue of the income limitation set for such buildings; shall be binding on all successors of the Applicant; and the Declaration of Land Use Restrictive Covenants incorporated within the Reservation and Extended Use Agreement shall be recorded pursuant to State law as a restrictive covenant.

(3) The Housing Credit allocation may not exceed the amount necessary for the financial feasibility of those units of the Project represented by the applicable fraction at the restricted rents specified in the Reservation and Extended Use Agreement.

(4) The Reservation and Extended Use Agree-ment shall include a commitment to meet the applicable fraction and restricted rent requirements for 15 years or more beyond the initial 15 year compliance period and may postpone for a specific time the project owner's rights under IRC Section 42(h)(6) to terminate the commitment after the initial 15 year compliance period.

[Publications: Publications referenced are available from the agency.
Stat. Auth.: ORS 456.515 - 456.720
Stats. Implemented: ORS 456.559(1)(f)
Hist.: HSG 14-1990, f. & cert. ef. 10-26-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 7-1991, f. & cert. ef. 12-19-91; Renumbered from 813-090-0029, OHCS 5-2013, f. & cert. ef. 6-21-13

813-090-0067
Non-Profit Set Aside

Ten percent of the Credit Authority for any calendar year shall be reserved for allocations to Projects involving a qualified non-profit low-income housing organization.

Stat. Auth.: ORS 183 & ORS 456.515 - 456.720
Stats. Implemented: ORS 456.559(1)(f)
Hist.: HSG 13-1987(Temp), f. & ef. 9-28-87; HSG 1-1988, f. & cert. ef. 3-8-88; HSG 3-1989(Temp), f. & cert. ef. 6-8-89; HSG 18-1989, f. & cert. ef. 11-3-89; HSG 12-1990(Temp), f. & cert. ef. 5-29-90; HSG 14-1990, f. & cert. ef. 10-26-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 7-1991, f. & cert. ef. 12-19-91; Renumbered from 813-090-0025, OHCS 5-2013, f. & cert. ef. 6-21-13

813-090-0080
Revocation or Reduction of Housing Credit

(1) The Department may refuse to make an offer, may revoke an offer of a Housing Credit allocation, or may terminate a Reservation and Extended Use Agreement, if the Department determines that:

(a) The proposed Project owner will not obtain a construction loan or building permit, or close its equity agreement for the proposed Project in a timely manner;

(b) The proposed Project will not be placed in service by the date mutually agreed upon;

(c) The proposed Project financing is not committed as indicated; or

(d) The Applicant has supplied misleading information.

(2) The Department may reduce the allocation amount identified in the Reservation and Extended Use Agreement prior to the issuance of a copy of a Carryover Allocation or Form 8609 to the project owner if the Department determines that the project requires a lesser amount of Housing Credit to be financially feasible.

(3) When the Department has issued a Carryover Allocation, the Department may reduce the allocation amount identified in the Carryover Allocation prior to the delivery of a copy of a Form 8609 to the Project owner if the Department determines that the project requires a lesser amount of Housing Credit than previously determined to be financially feasible.

(4) The Department may revoke a Carryover Allocation if the Department determines that at least 10% of the total project cost will not be expended by the end of the calendar year in which the Carryover Allocation is made, or that the Project will not be placed in service within two years following the calendar year in which a Carryover Allocation is made or by the dates mutually agreed upon.

Stat. Auth.: ORS 183 & 456.515 - 456.720
Stats. Implemented: ORS 456.559(1)(f)
Hist.: HSG 13-1987(Temp), f. & ef. 9-28-87; HSG 1-1988, f. & cert. ef. 3-8-88; HSG 3-1989(Temp), f. & cert. ef. 6-8-89; HSG 18-1989, f. & cert. ef. 11-3-89; HSG 12-1990(Temp), f. & cert. ef. 5-29-90; HSG 14-1990, f. & cert. ef. 10-26-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 7-1991, f. & cert. ef. 12-19-91; Renumbered from 813-090-0060, OHCS 5-2013, f. & cert. ef. 6-21-13

813-090-0095
Monitoring

(1) The Department shall notify the Internal Revenue Services (IRS) in writing of the non-compliance of any Project with the provisions of IRC Section 42 as they may apply to such Project and the Department shall not be liable to the Project or Project owner for any adverse consequences resulting from the Department notifying the IRS.

(2) The Department shall send a copy to the Project owner of any notification of non-compliance sent to the IRS regarding the project.

(3) The Department may require annual reports from the Project owner in order to facilitate the Department's monitoring of Project compliance.

(4) The Declaration of Land Use Restrictive Covenants and Reservation and Extended Use Agreement, of which it is a part, may be enforced by the Department or its designee in the event the Owner fails to satisfy any of the requirements therein.

(5) The Declaration of Land Use Restrictive Covenants shall be deemed a contract enforceable by one or more tenants as third-party beneficiaries of the Declaration of Land Use Restrictive Covenants and Reservation and Extended Use Agreement.

(6) In the event the Project owner fails to satisfy the requirements of the Declaration of Land Use Restrictive Covenants and Reservation and Extended Use Agreement and legal costs are incurred by the Department or one or more tenants or beneficiaries, such legal costs, including legal charges and court costs (including costs of an appeal), are the responsibility of and may be recovered from the project owner.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 456.515 - 456.720
Stats. Implemented: ORS 456.559(1)(f)
Hist.: HSG 12-1990(Temp), f. & cert. ef. 5-29-90; HSG 14-1990, f. & cert. ef. 10-26-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 7-1991, f. & cert. ef. 12-19-91; OHCS 9-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 8-2007, f. & cert. ef. 1-11-07; Renumbered from 813-090-0095, OHCS 5-2013, f. & cert. ef. 6-21-13

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Rule Caption: Renumbering the rules will improve readability for participants of the HOME Investments Partnerships Program.
Adm. Order No.: OHCS 6-2013
Filed with Sec. of State: 6-21-2013
Certified to be Effective: 6-21-13
Notice Publication Date:
Rules Renumbered: 813-120-0080 to 813-120-0025, 813-120-0090 to 813-120-0032, 813-120-0105 to 813-120-0045, 813-120-0070 to 813-120-0047
Subject: The HOME Investment Partnerships Program provides funds to construct or acquire and rehabilitate affordable multifamily rental housing for families of low and very low income, provides tenant-based rental assistance for individuals and families of low and very low income, and leverages local and private monies available from other sources for the purpose of developing appropriate low income and very low income multifamily rental housing.
Rules Coordinator: Sandy McDonnell—(503) 986-2012

813-120-0025
Application Procedure and Requirements

(1) The Department may distribute HOME funds, subject to availability of funds in the Program, through a process which may involve but is not limited to a first come — first reviewed process, demonstration program, a competitive review process, or as necessary to maintain an ongoing concern.

(a) Applications for HOME funds may include a pre-application and a final application. The completeness of information in pre-applications shall be the basis for inviting final applications.

(b) Each application submitted shall be reviewed by Department staff according to Program requirements and detailed Project evaluation criteria.

(2) The Applicant shall submit, on an application form and in accordance with the process prescribed by the Department, Applicant and Project information including but not limited to:

(a) Name, address and telephone number of the Applicant;

(b) Category of assistance requested;

(c) Amount requested and total Project costs, including a description and documentation of all additional Project funding and funding sources;

(d) A pro forma of Project income and expenses;

(e) The percentage of Match, as required by 24 C.F.R. § 92.218;

(f) A written description of the Project including the number of units, unit mix, proposed rents, site location, Project amenities, and any other information required in the application materials, Program guidelines or 24 C.F.R. Part 92;

(g) A statement of Project purpose indicating the housing type and tenants to be housed, and the length of time and the number of units that will be committed for occupancy by Low- and Very Low-Income Families;

(h) A description of how the proposed Project meets the regional or statewide needs and priorities addressed in and is consistent with Oregon's

Consolidated Plan or its successor, or documentation as to why the highest priority in the Applicant's community differs from the highest priorities outlined in Oregon's Consolidated Plan;

(i) A narrative of the experience of the sponsor/developer/owner/manager in developing and operating housing projects;

(j) A description of the Applicant's readiness to proceed on Project activities. Applicants should expect to begin construction activities within six months of execution of the HOME Agreement; and

(k) A schedule for completion of Project activities.

(3) Applicants must minimize Layering in Projects proposed for HOME funding in accordance 24 CFR 92.250 Subpart b, and the Department will not invest any more HOME funds in combination with other federal governmental assistance than is necessary to provide affordable housing to the targeted population.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 456.620
Stats. Implemented: ORS 456.559(1)(f)
Hist.: HSG 6-1992(Temp), f. & cert. ef. 6-15-92; HSG 10-1992, f. & cert. ef. 11-20-92; HSG 1-1993(Temp), f. & cert. ef. 2-19-93; HSG 3-1993, f. & cert. ef. 8-18-93; HSG 8-1994, f. & cert. ef. 9-9-94; HSG 3-1995, f. & cert. ef. 9-25-95; HSG 1-1997, f. & cert. ef. 4-15-97; OHCS 9-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 10-2007, f. & cert. ef. 1-11-07; OHCS 1-2008, f. & cert. ef. 1-28-08; Renumbered from 813-120-0080, OHCS 6-2013, f. & cert. ef. 6-21-13

813-120-0032
Application Review

(1) The Department shall consider an application and approve or deny the application, or request additional information within the timeframe set forth in the application materials.

(2). If the Department proposes to award HOME funds on an application requesting in excess of $100,000, it shall submit the application request to the State Housing Council for review. The Council shall approve or disapprove the application at a public hearing of the Council, pursuant to ORS 456.571(2).

(3) In reviewing applications for HOME assistance, the Department and the Council, as appropriate, may consider, in addition to any other or special evaluation criteria, the following:

(a) Amount of available funds in the HOME Program;

(b) Availability of other sources of assistance; and

(c) Applicant's efforts to leverage public or private funds.

(4) The Department may, in its sole discretion, further restrict the amount and/or type of assistance available or restrict the type of Applicant eligible for assistance.

(5) The Department shall select those applications which, in the judgment of the Department, best achieve the purposes of the HOME Program, this OAR chapter 813, division 120 (including the Program guidelines described in 813-120-0060(1)), and 24 C.F.R. Part 92, and meet the evaluation criteria outlined in the Program guidelines described in 813-120-0060(1). Applicants must document consistency with the priorities in Oregon's Consolidated Plan or its successor, or document why the highest priority in their communities differs from the highest priorities outlined in Oregon's Consolidated Plan or its successor. Projects that are not financially feasible shall not be funded.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 456.620
Stats. Implemented: ORS 456.559(1)(f)
Hist.: HSG 6-1992(Temp), f. & cert. ef. 6-15-92; HSG 10-1992, f. & cert. ef. 11-20-92; HSG 1-1993(Temp), f. & cert. ef. 2-19-93; HSG 3-1993, f. & cert. ef. 8-18-93; HSG 8-1994, f. & cert. ef. 9-9-94; HSG 3-1995, f. & cert. ef. 9-25-95; OHCS 1-2008, f. & cert. ef. 1-28-08: Renumbered from 813-120-0090, OHCS 6-2013, f. & cert. ef. 6-21-13

813-120-0045
Eligible Activities

(1) The Department may provide funds for the following categories of activities. The Department may restrict the availability of Program funds for each such category at the time it solicits applications.

(2) Homeowner Rehabilitation: For rehabilitation of single-family housing that is the principal residence of a homeowner whose Family is a Low-Income or Very Low-Income Family at the time of commitment of HOME funds. Homeowner rehabilitation programs shall be administered by a State Recipient or a Subrecipient.

(3) Homebuyer Assistance: For acquisition, rehabilitation and/or construction of housing to be owned and occupied by Low- or Very Low-Income Families.

(4) Rental Rehabilitation: For acquisition and/or rehabilitation of existing structures for rental housing affordable to Low- and Very Low-Income Families. The initial and long-term affordability requirements outlined in OAR 813-120-0050 shall apply to rental housing assisted with HOME funds. Rental rehabilitation projects may be sponsored by a State Recipient, Nonprofit Organization, For-Profit Organization, individual or CHDO.

(5) New Construction: For the construction of new rental housing or the acquisition of rental housing which is acquired within one year of the date of the certificate of initial occupancy. New construction Projects may be sponsored by a State Recipient, Nonprofit Organization, For-Profit Organization, individual or CHDO.

(6) Acquisition of vacant land or demolition is an eligible activity only when proposed as a portion of a particular Project intended to provide affordable housing. New Construction of housing is an eligible activity only when the initial certificate of occupancy was issued mor more than one year prior to the Commitment of Program Funds, and is otherwise approved by the Department. Building conversion is considered new construction if one or more untis are being added beyond the existing walls of the structure.

(7) Tenant-Based Rental Assistance: For rental assistance to Low- and Very Low-Income Families.

(8) CHDO Predevelopment and Technical Assistance: Loans for project-specific predevelopment or technical assistance and site control activities performed by CHDOs may be authorized for up to 10 percent of the Program's allocation set-aside for CHDOs, as described in 24 C.F.R. Sec. 92.208, 92.300(e) and (f).

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 456.620
Stats. Implemented: ORS 456.559(1)(f)
Hist.: HSG 6-1992(Temp), f. & cert. ef. 6-15-92; HSG 10-1992, f. & cert. ef. 11-20-92; HSG 1-1993(Temp), f. & cert. ef. 2-19-93; HSG 3-1993, f. & cert. ef. 8-18-93; HSG 8-1994, f. & cert. ef. 9-9-94; HSG 1-1997, f. & cert. ef. 4-15-97; Renumbered from 813-120-0030, OHCS 1-2008, f. & cert. ef. 1-28-08: Renumbered from 813-120-0105, OHCS 6-2013, f. & cert. ef. 6-21-13

813-120-0047
Distribution and Expenditure of Funds

(1) The Department will follow the allocation strategies as outlined in the Consolidated Plan or its successor the program information described in OAR 813-120-0060 which may distribute funds based on a formula that takes onto account the relative housing needs of regions or other factors, distribute funds on a statewide basis, or may consider some other means of distribution.

(2) As opportunities arise, the Department may use HOME funds for the demonstration and development of new activities.

(3) The Department shall use its best efforts to make commitments for Projects under the State's HOME allocation for a fiscal year within two years after the month in which that allocation is approved by HUD. All HOME funds committed to a Project under the State's HOME allocation for a fiscal year shall be expended within five years after the month in which the HOME allocation for that fiscal year is approved by HUD.

(4) A Recipient shall begin expenditure of its HOME funds within six months of the date the HOME Agreement between the Recipient and the Department is executed. The Department may, in its sole discretion, permit extension(s) upon submission by the Recipient of documentation acceptable to the Department.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 456.620
Stats. Implemented: ORS 456.559(1)(f)
Hist.: HSG 6-1992(Temp), f. & cert. ef. 6-15-92; HSG 10-1992, f. & cert. ef. 11-20-92; HSG 1-1993(Temp), f. & cert. ef. 2-19-93; HSG 3-1993, f. & cert. ef. 8-18-93; HSG 8-1994, f. & cert. ef. 9-9-94; HSG 3-1995, f. & cert. ef. 9-25-95; HSG 1-1997, f. & cert. ef. 4-15-97; OHCS 1-2008, f. & cert. ef. 1-28-08: Renumbered from 813-120-0070, OHCS 6-2013, f. & cert. ef. 6-21-13

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Rule Caption: Renumbering the rules will improve readability for participants of the General Housing Program.
Adm. Order No.: OHCS 7-2013
Filed with Sec. of State: 6-21-2013
Certified to be Effective: 6-21-13
Notice Publication Date:
Rules Renumbered: 813-055-0030 to 813-055-0075, 813-055-0070 to 813-055-0085, 813-055-0080 to 813-055-0105, 813-055-0090 to 813-055-0115
Subject: The General Housing Account carries out the allocation of monies deposited in the General Housing Account to meet critical housing needs, building the organizational capacity of affordable housing partners throughout the state, and requiring equitable distribution of resources over time based on objective measures of need.
Rules Coordinator: Sandy McDonnell—(503) 986-2012

813-055-0075
Distribution of Funds

The Department shall develop a distribution method for both Multifamily Affordable Housing Development and Affordable Housing Capacity Building which provides for an equitable distribution of resources statewide over time based on objective measures of need, including, but not limited to:

(1) The number and percentage of low and very-low income households in an area;

(2) The estimated need for affordable housing as determined by the Department and Council; and

(3) The need of a nonprofit or housing authority to build its capacity to develop and operate housing serving low and very low income populations.

Stat. Auth.: ORS 456.515 - 456.725 & 458.600 - 458.660
Stats. Implemented: ORS 458.660
Hist.: OHCS 5-2009, f. & cert. ef. 12-22-09; Renumbered from 813-055-0030, OHCS 7-2013, f. & cert. ef. 6-21-13

813-055-0085
Charges

(1) The Department may impose a charge from any applicant requesting General Housing Account funds.

(2) For Multifamily Affordable Housing Development awards, the Department may require a transfer application charge from owners of projects that receive contracts, grants, loans, or tax credits through the Department, who request the Department's approval of a change in project ownership. The Department may assess a transfer review charge to project owners and transferees who effect a change in project ownership without prior written Department approval.

(3) The Department may charge for Department of Justice time required for review of applicant requested changes to proscribed documents.

Stat. Auth.: ORS 456.515 - 456.725 & 458.600 - 458.660
Stats. Implemented: ORS 458.660
Hist.: OHCS 5-2009, f. & cert. ef. 12-22-09; Renumbered from 813-055-0070, OHCS 7-2013, f. & cert. ef. 6-21-13

813-055-0105
General Administrative and Monitoring Requirements

(1) The Department's monitoring of Program compliance may require annual reports from the recipient.

(2) The Department may perform such reviews or field inspections as it deems necessary to ensure Program compliance. The Department may require that a recipient take such remedial actions as described in the terms and conditions of the award and OAR 813-52-0090.

(3) Financial records, supporting documents, and all other pertinent records shall be retained by a General Housing Account recipient for six years after the project is complete, or after any litigation or audit claim is resolved, whichever is later. The Department shall have access to all books, accounts, documents, records and other property belonging to or in use by the recipient which relate to the use of General Housing Account funds.

Stat. Auth.: ORS 456.515 - 456.725 & 458.600 - 458.660
Stats. Implemented: ORS 458.660
Hist.: OHCS 5-2009, f. & cert. ef. 12-22-09; Renumbered from 813-055-0080, OHCS 7-2013, f. & cert. ef. 6-21-13

813-055-0115
Remedies for Noncompliance

At any time before the expiration of the affordability period, the Department may find that a recipient is not in compliance with the requirements of the Program for reasons including but not limited to use of funds for activities not approved in the Use Agreement, failure to complete activities in a timely manner, failure to comply with applicable rules or regulations, or the lack of a continued capacity by the recipient to carry out the approved activities. Remedies for noncompliance may include penalties imposed by the Department, including but not limited to, repayment of General Housing Account funds.

Stat. Auth.: ORS 456.515 - 456.725 & 458.600 - 458.660
Stats. Implemented: ORS 458.660
Hist.: OHCS 5-2009, f. & cert. ef. 12-22-09; Renumbered from 813-055-0090, OHCS 7-2013, f. & cert. ef. 6-21-13

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Rule Caption: Amends the procedural rules for State Housing Council Review and Determination for award proposals
Adm. Order No.: OHCS 8-2013(Temp)
Filed with Sec. of State: 6-21-2013
Certified to be Effective: 6-21-13 thru 12-18-13
Notice Publication Date:
Rules Amended: 813-001-0007
Subject: The Descriptive and Procedural Rules provide an overview of the Department and related entities. The rules describe the general procedural rules with respect to the review and approval or disapproval by the State Housing Council of certain housing grants, loans and other funding awards proposed to it by the Director of the Department. The department has completed a significant reorganization as to how it solicits and administers funding awards for this program as part of the restructure. These rule changes are designed to reflect the significant reorganization of the department.
Rules Coordinator: Sandy McDonnell—(503) 986-2012

813-001-0007
Procedural Rules for State Housing Council Review and Determination with Respect to Certain Housing Loan, Grant and Other Funding Award Proposals by the Director

(1) The Director or the Director's Department designees shall submit proposed loan, grant or other funding award proposals arising under ORS 456.515 to 456.725 programs to the State Housing Council for review and approval if the proposal is for:

(a) A proposed single-family loan on property with a purchase price which, when reduced by costs of purchase other than the Department loan, is equal to or greater than seventy-five percent of the applicable area program purchase price limit or $190,000, whichever is greater; or;

(b) A housing grant or other housing funding award with respect to a multifamily housing project equal to or greater than $200,000 per funding source with an aggregate minimum threshold per project of $400,000.

(2) The Council shall review each loan, grant or other funding award proposal submitted by the Director under this section and approve or disapprove the loan, grant or other funding award proposal. An approval by the Council of any loan, grant or other funding award may be partial or in full and may contain any conditions that the Council may prescribe.

(3) Formal Council review of loan, grant or other funding award proposals under this section shall be conducted in a public meeting, whether in person or by telephone or other electronic means. The Council may go into executive session, as appropriate, in the course of its review. A Council public meeting notice, when required by ORS 192.640, shall include notice of the loan, grant or other funding award proposal review, the names of the applicants, and the subject of the loan, grant or funding award proposal. The Council also shall provide notice of any loan, grant or other funding award proposal review to the loan, grant or other funding award applicant not less than five days before the review hearing.

(4) The public may contact the Department for available information with respect to prospective Council review of loan, grant or other funding award proposals by telephoning 503.986-2000 or addressing written correspondence to: Oregon Housing and Community Services Department, 725 Summer Street NE, Suite B, Salem OR 97301.

(5) Procedural rules addressing other programs administered by the Department are included, where applicable, in other divisions of this chapter. Additional procedural rules with respect to the review and approval of housing grants, loans and other funding awards also may be included, where applicable, in other divisions of the chapter.

Stat. Auth.: ORS 90.630, 90.771 - 90.775, 90.800 - 90.840, 183, 315.271, 317.097, 446.525 - 446.543, 456.515 - 456.725, 458.210 - 458.365, 458.405 - 458.460, 458.505 - 458.740, 566.310 - 566.350 & 757.612 - 757.617
Stats. Implemented: ORS 90.630, 90.771 - 90.775, 90.800 - 90.840, 183, 315.271, 317.097, 446.525 - 446.543, 456.515 - 456.725, 458.210 - 458.365, 458.405 - 458.460, 458.505 - 458.740, 566.310 - 566.350 & 757.612 - 757.617
Hist.: OHCS 2-2005(Temp), f. & cert. ef. 8-4-05 thru 1-31-06; OHCS 2-2006, f. & cert. ef. 1-31-06; OHCS 8-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

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Rule Caption: Amends the process for soliciting and administering funding awards for Oregon Affordable Housing Tax Credits
Adm. Order No.: OHCS 9-2013(Temp)
Filed with Sec. of State: 6-21-2013
Certified to be Effective: 6-21-13 thru 12-18-13
Notice Publication Date:
Rules Adopted: 813-110-0024, 813-110-0027, 813-110-0032, 813-110-0034, 813-110-0037, 813-110-0045
Rules Amended: 813-110-0005, 813-110-0010, 813-110-0015, 813-110-0020, 813-110-0021, 813-110-0022, 813-110-0025, 813-110-0030, 813-110-0035, 813-110-0040

Rules Suspended: 813-110-0012, 813-110-0013, 813-110-0023, 813-110-0033, 813-110-0050

Subject: The Oregon Affordable Housing Tax Credits Program encourages the creation or preservation of safe, sanitary and affordable housing for lower income Oregonians. The department has completed a significant reorganization as to how it solicits and administers funding awards for this program as part of the restructure. These rule changes are designed to reflect the significant reorganization of the department.

Rules Coordinator: Sandy McDonnell—(503) 986-2012

813-110-0005
Purpose and Objectives

OAR chapter 813, division 110, is promulgated to carry out the provisions of ORS 317.097 under which the department certifies affordable multifamily rental housing development projects sponsored by government entities, nonprofit corporations and certain persons ("sponsoring entities" or "sponsors") so as to enable a lending institution to claim Oregon affordable housing tax credits ("OAHTC" or "tax credits") against Oregon taxes with respect to loans for the construction or acquisition, and rehabilitation of such projects. The purpose of the tax credits is to encourage the creation or preservation of safe, sanitary and affordable housing for lower-income Oregonians. Additional policies and instructions are outlined in the Oregon Affordable Housing Tax Credits (OAHTC) Manual dated June 21, 2013 (the "OAHTC Manual" or "Manual"), incorporated herein by reference. The Manual may be accessed online at the Department's website.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: HSG 1-1990(Temp), f. & cert. ef. 1-5-90; HSG 3-1990(Temp), f. & cert. ef. 3-1-90; HSG 9-1990, f. & cert. ef. 5-11-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 2-1994(Temp), f. & cert. ef. 3-25-94; HSG 7-1994, f. & cert. ef. 9-9-94; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06; OHCS 14-2007(Temp), f. & cert. ef. 10-16-07 thru 4-12-08; OHCS 5-2008, f. & cert. ef. 4-11-08; OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-110-0010
Definitions

Certain terms used in this division are defined in ORS Chapter 317, the Act, OAR 813-005-0005, and herein. Other terms may be identified in the text of this division (including by incorporation), otherwise in chapter 813, or applicable law.

Stat. Auth.: ORS 317.097, 456.555
Stats. Implemented: ORS 317.097, 456.625
Hist.: HSG 1-1990(Temp), f. & cert. ef. 1-5-90; HSG 3-1990(Temp), f. & cert. ef. 3-1-90; HSG 9-1990, f. & cert. ef. 5-11-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 2-1994(Temp), f. & cert. ef. 3-25-94; HSG 7-1994, f. & cert. ef. 9-9-94; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06; OHCS 11-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 9-2007, f. & cert. ef. 1-11-07; OHCS 14-2007(Temp), f. & cert. ef. 10-16-07 thru 4-12-08; OHCS 5-2008, f. & cert. ef. 4-11-08; OHCS 1-2009(Temp), f. & cert. ef. 2-9-09 thru 8-7-09; OHCS 2-2009, f. & cert. ef. 8-5-09; OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-110-0012
Sponsor Criteria

(1) A Sponsor may be any Person, subject to the approval of the Department and including a nonprofit or local government entity but not limited to a housing authority, that enters into restrictive covenants regarding the rents on the property and eligibility of occupants.

(2) A Sponsor may be an authorized agent of a Lending Institution in a local owner-occupied community rehabilitation program.

(3) A Sponsor may be a borrower that reloans the proceeds of a loan to participating individuals in a community rehabilitation program.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: OHCS 7-2006, f. & cert. ef. 5-17-06; Suspended by OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-110-0013
Loan Requirements

In order to be eligible for the tax credit, the loan shall be:

(1) Made to an individual or individuals who own the dwelling, who participate in an owner-occupied community rehabilitation program, and are certified by the local government or its designated agent as having an income level at the time the loan is made of less than 80 percent of the area median income.

(2) Made to a qualified borrower;

(a) Used to finance construction, development, acquisition, or rehabilitation of housing; and,

(b) Accompanied by a written certification by the department that the:

(A) Housing created by the loan is or will be occupied by households earning less than 80 percent of the area median income; and,

(B) Full amount of the savings, from the reduced interest rate provided by the lending institution, is or will be passed on to the tenants in the form of reduced housing payments, regardless of other subsidies provided to the housing project, or

(3) Made to a qualified borrower;

(a) Used to finance construction, development, acquisition, or acquisition and rehabilitation of housing consisting of a manufactured dwelling park;

(b) The housing created by the loan is or will be occupied by a significant number of households, defined as more than 30% of all households at initial tenant qualification, earning less than 80 percent of the area median income; and,

(c) Accompanied by a written certification by the department that the housing will continue to be operated as a manufactured dwelling park during the period for which the tax credit is allowed, or

(4) Made to a qualified borrower;

(a) Used to finance acquisition, or acquisition and rehabilitation, of housing consisting of a preservation project; and,

(b) Accompanied by a written certification by the department that the housing preserved by the loan:

(A) Is or will be occupied by households earning less than 80 percent of the area median income; and

(B) Has a rent assistance contract with the United States Department of Housing and Urban Development (HUD) or the United States Department of Agriculture that will be maintained by the qualified borrower. The contract must provide rental assistance to households in at least 25% of the project units.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: OHCS 14-2007(Temp), f. & cert. ef. 10-16-07 thru 4-12-08; OHCS 5-2008, f. & cert. ef. 4-11-08; Suspended by OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-110-0015
Application Requirements

(1) For the purpose of enabling a lending institution to obtain a reservation of OAHTC under ORS 317.097, a sponsoring entity may apply to the Department for certification of a qualified loan for the allocation of OAHTC consistent with OAR chapter 813 pursuant to relevant solicitation documents issued by the Department including, but not limited to a Notice of Funding Availability ("NOFA"), or as otherwise determined by the Department. The application shall provide information satisfactory to the Department including, but not limited to:

(a) The name, address and telephone number of the sponsoring entity;

(b) Proof as required by the Department that the sponsoring entity is a qualified borrower;

(c) The relevant background of the qualified borrower and its management agent and their expertise with housing for low-income persons, if applicable;

(d) A firm commitment of financing by the lending institution to the sponsoring entity for the property that is the subject of the tax credits claim containing all of the terms and conditions that the sponsoring entity has to satisfy before the loan will be funded and including an estimated comparable market interest rate for the proposed loan, the estimated reduced interest rate and the estimated amount of savings or a letter of intent for the purpose of a reservation under OAR 813-110-0030;

(e) The name, address and contact person of the lending institution making the loan;

(f) A description of the project, including the type of housing or program involved, the number and type of housing units to be provided, the number of bedrooms, the address where the project is or will be located, and the federal, state and local agencies or organizations involved in financing or managing the project;

(g) An agreement by the sponsoring entity to execute restrictive covenants satisfactory to the Department to which covenants will be recorded at the time of loan closing;

(h) A demonstration relating to occupancy of the units in the project, as required by subsection (2) of this section;

(i) A demonstration that the project meets the minimum requirements of any other Department program used by the project, as required by subsection (3) of this section;

(j) Any additional information or actions requested by the Department; and

(k) A certification by the sponsoring entity that includes, at a minimum, the statement that all information in the application is true, complete and accurately describes the project.

(2) The following provisions apply to the demonstration relating to occupancy of units that is required in subsection (1) of this section:

(a) A demonstration for a project other than a manufactured dwelling park must show that units constructed or rehabilitated with OAHTC will be occupied by households earning less than 80 percent of adjusted area median income at the time of initial occupancy.

(b) In the case of a preservation project or a manufactured dwelling park awarded after September 27, 2007, a pass-through is not required for a certification produced on or after September 27, 2007.

(c) For a project other than a project to which paragraph (b) of this subsection applies, the demonstration must show that at the time the project is initially rented or purchased, and thereafter for the term of the OAHTC or twenty years, whichever is longer, the sponsor will pass the benefits of the project's reduced loan interest rate to tenant or homeowner households whose earnings are less than 80 percent of area median income at the time of initial tenant or homeowner qualification.

(d) A demonstration for a manufactured dwelling park must show that the project meets the occupancy requirements applicable to manufactured dwelling parks in ORS 317.097.

(3) Because the OAHTC Program is intended to lower rents below the level that would obtain after all other subsidies have been applied, a project that uses one or more other Department programs must demonstrate that the project meets or will meet the minimum requirements of those other programs before application of the OAHTC subsidy rent reduction. For example, if an applicant has applied for tax credits under the Low Income Housing Tax Credit (LIHTC) Program and that application indicated a target of 60 percent of area median income rents, the application under this rule must show the project is feasible at the targeted 60 percent median rents without the OAHTC subsidy. The OAHTC subsidy must be applied to reduce rents below the 60 percent level and must be passed on directly to the OAHTC qualified tenants or homeowners in its entirety although the pass-through need not be distributed evenly among the units.

(4) Rental units covered by Section 8 Project Based Assistance are not eligible to be used to demonstrate pass-through savings for the OAHTC program because the rent reductions related to the OAHTC subsidy typically would not be passed on to the tenants in the form of a rent reduction from what the tenants would otherwise pay, and therefore, would not achieve pass-through savings. Projects that are partially covered with Project Based Assistance may qualify to use OAHTC on the remaining units by, inter alia, demonstrating pass-through interest savings that result in appropriate rent reductions to the OAHTC qualified tenants.

(5) The Department may require more extensive and enduring affordability covenants than provided in subsections (2) through (4) as may be reflected in relevant solicitation documents or otherwise.

(6) The Department may require a nonrefundable application charge and may assess such other charges as it deems reasonable to cover anticipated costs of processing the application, coordinating with other funding or project partners, negotiating and recording required documents or additional administration. Certain other charges are identified later in these rules

Stat. Auth.: ORS 317.097

Stats. Implemented: ORS 317.097, 456.508, 456.510, 456.513, 456.559, 456.605, 456.722

Hist.: HSG 1-1990(Temp), f. & cert. ef. 1-5-90; HSG 3-1990(Temp), f. & cert. ef. 3-1-90; HSG 9-1990, f. & cert. ef. 5-11-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 2-1994(Temp), f. & cert. ef. 3-25-94; HSG 7-1994, f. & cert. ef. 9-9-94; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06; OHCS 11-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 9-2007, f. & cert. ef. 1-11-07; OHCS 14-2007(Temp), f. & cert. ef. 10-16-07 thru 4-12-08; OHCS 5-2008, f. & cert. ef. 4-11-08; OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-110-0020
Application Review

(1) Applications for a reservation of OAHTC, or for an OAHTC certification of award if conditions are met as required under OAR 813-110-0015 are subject to Department review.

(a) Any resulting reservation or certification of award may include modifications to the application and may be rescinded if conditions subsequent are not satisfied, including but not limited to the requirement to timely acquire a qualified funder who will appropriately use the tax credits.

(2) When a reservation or certification of award is made through a solicitation process, the reservation or certification of award will be subject to conditions identified in the solicitation documents that may differ from or supplement OAR 813-110-0021. When a reservation or certification of award is made outside of a solicitation process, the Department may specify additional conditions that may differ from or supplement OAR 813-110-0021

(3) Criteria that the Department may apply in considering an application include, but are not limited to the following:

(a) The experience of the sponsoring entity, property management agent and other involved person in providing low-income housing;

(b) Estimated rents that would have to be charged or the purchase price that would be required in order to make the project financially feasible, for the type and location of housing to be provided;

(c) The dollar amount of estimated savings from the reduction in rents from the estimated rents under paragraph (b) of this subsection, or the reduction in purchase price, owing to the OAHTC subsidy;

(d) The estimated rent reduction or purchase price reduction under paragraph (c) of this subsection;

(e) How long the tax credits are needed to meet the sponsoring entity's goals of long-term safe, sanitary and affordable housing;

(f) Except for manufactured dwelling park or preservation projects awarded after September 27, 2007, the sponsoring entity's statement that the proposed rent reduction or reduced purchase price will be maintained for or offered to households whose annual incomes are less than 80 percent of area median income;

(g) If the project is a preservation project, whether the project-based contract for rental assistance from the U.S. Department of Housing and Urban Development or the U.S. Department of Agriculture covers at least 25 percent of all units in the project;

(h) Restrictive covenants that provide for, but are not limited to, appropriate habitability, income and rent restrictions;

(i) A certifying statement from the agent for the lending institution of a local owner-occupied community rehabilitation program, if applicable;

(j) The target population to be served;

(k) The need for such affordable housing in the area to be served;

(l) Consistency with the comprehensive housing plan for the state or community;

(m) The location of the project site, including its proximity to transportation, shopping, social, commercial and recreational facilities, medical services and such other facilities and services that best serve the residents;

(n) Availability of street, sewer, water, utilities and other public services;

(o) Architectural design, including aesthetic quality, soundness of construction, energy efficiency, and suitability to the needs of the residents to be served;

(p) Compliance with applicable local comprehensive plan and land use regulations, housing codes and other applicable standards;

(q) The experience of the developer, contractors, architects, consultants and management agents in developing, constructing and operating housing projects; and

(r) The Department's experience with and the reputation, experience and capacity of the sponsoring entity, project owner and developer and their agents, representatives, employees and contractors.

(4) Applications are subject to review by the Department under this rule according to a process that may include, but need not be limited to an invitation only, a first-come first-reviewed or a competitive review process.

(5) The amount of a reservation or certification of award made pursuant to an application under this Division, together with the total outstanding tax credits, may not exceed the maximum allowable amount of tax credits for a project established under program requirements including, but not limited to those established in ORS 317.097.

Stat. Auth.: ORS 317.097

Stats. Implemented: ORS 317.097, 456.508, 456.510, 456.513, 456.559, 456.605, 456.722

Hist.: HSG 1-1990(Temp), f. & cert. ef. 1-5-90; HSG 3-1990(Temp), f. & cert. ef. 3-1-90; HSG 9-1990, f. & cert. ef. 5-11-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 7-1994, f. & cert. ef. 9-9-94; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06; OHCS 14-2007(Temp), f. & cert. ef. 10-16-07 thru 4-12-08; OHCS 5-2008, f. & cert. ef. 4-11-08; OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-110-0021
Reservation in Lieu of Certification

(1) For a reservation granted under OAR 813-110-0020:

(a) Except as provided in subsection (2) of this section, the reservation is valid for 180 days and is subject to extension by the Department at its sole discretion; and

(b) Is a confirmed reservation unless the lending institution modifies the original letter of intent or there is a failure to comply with material terms of the reservation.

(2) A reservation for a sponsoring entity that is a local government entity providing a community rehabilitation program or rental project may

be made for the period of proposed financing and may be extended at the discretion of the Department.

(3) A sponsor that furnishes the Department a firm commitment of financing prior to the expiration of a reservation is eligible, subject to other program requirements, for issuance of a certification.

(4) A sponsor to which a reservation has been issued shall notify the Department of any change in the lending institution as well as any failure to comply with a material term of the reservation.

Stat. Auth.: ORS 317.097
Stats. Implemented: ORS 317.097, 456.508, 456.510, 456.513, 456.559, 456.605, 456.722
Hist.: HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 7-1994, f. & cert. ef. 9-9-94; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06; OHCS 14-2007(Temp), f. & cert. ef. 10-16-07 thru 4-12-08; OHCS 5-2008, f. & cert. ef. 4-11-08; OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-110-0022
Set-Aside

(1) A portion of the maximum amount of tax credits established in ORS 317.097 is subject to either or both of the following:

(a) A set-aside by the Department for projects that meet Department identified goals under the OAHTC Program.

(b) One or more set-asides established by the Department from time to time, when directed by the State Housing Council, to meet housing needs in various economic or geographic regions of the state.

(2) At the Department's direction, a sponsoring entity that does not qualify for a set-aside under subsection (1) of this section may request that the Department approve a set-aside on alternate grounds as provided in this subsection. The sponsoring entity must demonstrate to the Department's satisfaction that the sponsoring entity meets criteria similar to those used in the needs assessment in Oregon's plan that is approved by the U.S. Department of Housing and Urban Development (HUD) and that describes the needs, resources, priorities and proposed activities to be undertaken with respect to programs of that department. The Department may approve or deny a set-aside on the basis of its consideration of a request under this subsection.

Stat. Auth.: ORS 317.097
Stats. Implemented: ORS 317.097, 456.508, 456.510, 456.513, 456.559, 456.605, 456.722
Hist.: HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 7-1994, f. & cert. ef. 9-9-94; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06; OHCS 14-2007(Temp), f. & cert. ef. 10-16-07 thru 4-12-08; OHCS 5-2008, f. & cert. ef. 4-11-08; OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-110-0023
Standby Applications

The Department may, at its discretion, establish a standby list and criteria relating to it for Applications which are in excess of the Cap or a set-aside amount.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 2-1994(Temp), f. & cert. ef. 3-25-94; HSG 7-1994, f. & cert. ef. 9-9-94; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06; Suspended by OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-110-0024
Reservations, Certifications and Other Commitments Subject to State Housing Council Approval

If the Department provides a reservation, certification of award or otherwise commits to an award of OAHTC under this Division and if the amount of any related tax credits or any other Department funding approved by the Department that was considered by the Department in setting the amount of the tax credits ("Complementary Funding") meets or exceeds the threshold amount established in OAR 813-001-0007(1) for review by the State Housing Council, the reservation, certification or other commitment is subject to review and approval by the Council of such tax credit assistance and any such Complementary Funding. The Council may approve, deny, modify or further condition funding assistance subject to its review. Based upon any relevant Council determination, including with respect to Complementary Funding, any subject reservation, certification or other commitment may be deemed revoked, be modified or be further conditioned.

Stat. Auth.: ORS 317.097
Stats. Implemented: ORS 317.097, 456.508, 456.510, 456.513, 456.559, 456.605, 456.625 and 456.722
Hist.: OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-110-0025
Certification of Eligible Projects

(1) When the Department determines that it may issue a certification to a lending institution as authorized by ORS 317.097, the certification will include, inter alia, the following as applicable:

(a) The proposed borrower is an eligible sponsor;

(b) The proposed borrower has demonstrated that the required benefits will be passed on to households earning less than 80 percent of area median income, except for manufactured dwelling park projects, according to program requirements including, but not limited to those in ORS 317.097 and this Division.

(c) The length of the period eligible for tax credits; and

(d) The loan does not exceed the maximum limitation for total loan balances.

(2) A certification is based on information provided by the sponsoring entity in the application and accumulated from the lending institution's annual reports required by OAR 813-110-0030 and conditioned, inter alia, upon the accuracy of such information.

(3) A certification is valid for the purpose of the tax credit only if the information on which the certification is based, other than estimates based on interest rates and other changes made with the approval of the department, is unchanged when the loan is closed for the project and when funding documents satisfactory to the Department including, but not limited to an appropriate declaration of restrictive covenants, have been executed and, as required by the Department, recorded in the official records of the appropriate counties.

(4) To establish the use of a certificate for a fixed rate term loan, a lending institution shall, inter alia, complete the loan closing information section of the certificate and send the original to the department along with evidence satisfactory to the Department that the declaration of restrictive covenants required for the tax credits has been recorded against the project property.

(5) When the Department approves tax credits for a construction loan, the lending institution shall, inter alia, complete the loan closing information section of the certificate and send the original to the department with evidence satisfactory to the Department that an appropriate declaration of restrictive covenants has been recorded or will be recorded at the close of permanent financing (as required by the Department) against the project property.

Stat. Auth.: ORS 317.097
Stats. Implemented: ORS 317.097, 456.508, 456.510, 456.513, 456.559, 456.605, 456.722
Hist.: HSG 1-1990(Temp), f. & cert. ef. 1-5-90; HSG 3-1990(Temp), f. & cert. ef. 3-1-90; HSG 9-1990, f. & cert. ef. 5-11-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 7-1994, f. & cert. ef. 9-9-94; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06; OHCS 14-2007(Temp), f. & cert. ef. 10-16-07 thru 4-12-08; OHCS 5-2008, f. & cert. ef. 4-11-08; OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-110-0027
Certification Request by Lending Institution

(1) A lending institution shall submit a separate application for each certification of a sponsoring entity requested under the Oregon Affordable Housing Tax Credits Program.

(2) A lending institution shall pay a charge to the Department as assessed by the Department for each application for a certification.

Stat. Auth.: ORS 317.097
Stats. Implemented: ORS 317.097, 456.508, 456.510, 456.513, 456.559, 456.605, 456.722
Hist.: OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-110-0030
Monitoring and Reporting Requirements

(1) A lending institution claiming state tax credits under ORS 317.097 is subject to monitoring by the Department. A lending institution shall submit to the Department by May 1 of each year a report satisfactory to the Department in which the lending institution affirms that the lending institution has met all requirements imposed by law to qualify for the tax credits. The report must be submitted on a form furnished by the Department and signed by an officer of the lending institution, and:

(a) May not include any representation as to the performance by the sponsoring entity; and

(b) Shall include, at a minimum, the name and address of the institution, the name and phone number of a contact person, the number of loans for which tax credits will be claimed, the amount of credit claimed, the annual charge payment, the dates the loans were closed, the location of the projects financed by those loans, the amount loaned for each project, the outstanding balances of all loans, and the average annual balance for each loan.

(2) A project receiving OAHTC is subject to reviews and field inspections that the Department determines to be necessary or appropriate including, but not limited to ensuring the sponsoring entity's and project owner's compliance with program requirements including, but not limited to OAR chapter 813 (including the OAHTC Manual and General Manual), Department directives, relevant documents, applicable law or otherwise.

The project owner shall cooperate fully with all reviews and field inspections, comply with any resulting correction directives, and shall make all records available for inspection and copying.

(3) A project owner shall retain financial records, supporting documents and all other pertinent records for six years after the project affordability period is complete, or after any litigation or audit claim is resolved, whichever is later.

Stat. Auth.: ORS 317.097
Stats. Implemented: ORS 317.097, 456.508, 456.510, 456.513, 456.559, 456.605, 456.722
Hist.: HSG 1-1990(Temp), f. & cert. ef. 1-5-90; HSG 3-1990(Temp), f. & cert. ef. 3-1-90; HSG 9-1990, f. & cert. ef. 5-11-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 7-1994, f. & cert. ef. 9-9-94; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06; OHCS 11-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 9-2007, f. & cert. ef. 1-11-07; OHCS 14-2007(Temp), f. & cert. ef. 10-16-07 thru 4-12-08; OHCS 5-2008, f. & cert. ef. 4-11-08; OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-110-0032
Supplemental Application Charge

A sponsoring entity of a project under the OAHTC Program shall pay a supplemental application charge, as established by the Department from time to time, when the sponsoring entity requests additional resources for a project that has already been funded under the program.

Stat. Auth.: ORS 317.097
Stats. Implemented: ORS 317.097, 456.508, 456.510, 456.513, 456.559, 456.605 and 456.722
Hist.: OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-110-0033
Charges

(1) The Department may require a non-refundable application charge from any applicant requesting Oregon Affordable Housing Tax Credits through the Consolidated Funding Cycle or otherwise.

(2) The Department may require a supplemental application charge from applicants requesting additional resources for projects that have already been funded by the Department.

(3) The Department may require a transfer application charge from owners of projects that receive grants or tax credits through the Department, who request the Department's approval of a change in project ownership. The Department may assess a transfer review charge to project owners and transferees who effect a change in project ownership without prior written Department approval.

(4) A base charge of 5 percent of the annual tax credits claimed by an eligible Lending Institution plus $100 per month for each full month the annual report is delayed shall be paid by the Lending Institution to the Department.

(5) On Projects certified prior to September 29, 1991, all annual charges required in OAR 813-110-0033, except for any charges for delayed reports, shall be waived.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 7-1994, f. & cert. ef. 9-9-94; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06; OHCS 11-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 9-2007, f. & cert. ef. 1-11-07; Suspended by OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-110-0034
Transfer of Loan, Owner, or Project

(1) An owner of a project that has received OAHTC assistance or recipient of a loan subsidized by such assistance shall not transfer or allow any transfer of any interest in itself, the loan or the project or otherwise encumber the project, or any portion or interest therein, unless the Department first approves the transfer or encumbrance in writing. Any such transfer is subject to payment to the Department by the borrower or owner, as applicable, of a transfer charge as required by the Department. If the borrower or owner effects or allows a transfer without prior written approval by the Department, the transfer is voidable and remains subject to the approval or disapproval of the Department and the borrower or owner and transferees, jointly and severally, are subject to a transfer review charge by the Department.

(2) The Department may condition its approval upon such terms and conditions as it, at its sole discretion, may require. Factors the Department may consider in determining whether or not to give approval to a transfer include but are not limited to:

(a) The financial investment of the Department in the project;

(b) Preservation of existing housing;

(c) The proposed owner's ability to maintain and manage the property for the needs of the residents, the integrity of the housing and as security for the loan;

(d) The effect of the transfer upon the financial integrity of the project, repayment of the loan, use of the project for its intended purposes, and continuity of the program; and

(e) Continued compliance with applicable program requirements including, but not limited to terms and conditions of funding documents and state and federal laws, rules and regulations.

Stat. Auth.: ORS 317.097
Stats. Implemented: ORS 317.097, 456.508, 456.510, 456.513, 456.559, 456.605, 456.722
Hist.: OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-110-0035
Community Rehabilitation Project Certification

(1) A local government or its designated agent that certifies a participant in a community rehabilitation program shall certify to the Department that the tax credits for the community rehabilitation program fall within the maximum amount of tax credits authorized in ORS 317.097.

(2) A participant in a community rehabilitation program includes any individual, nonprofit corporation or unit of local government that re-loans proceeds to an individual participating in the community rehabilitation program.

(3) A local government entity shall certify to the Department that the local community rehabilitation standards will be met for all relending of proceeds from a certified loan.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: HSG 9-1990, f. & cert. ef. 5-11-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; OHCS 7-2006, f. & cert. ef. 5-17-06; OHCS 11-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 9-2007, f. & cert. ef. 1-11-07; OHCS 14-2007(Temp), f. & cert. ef. 10-16-07 thru 4-12-08; OHCS 5-2008, f. & cert. ef. 4-11-08; OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-110-0037
Use of Project; Transfer of Title

(1) The sponsoring entity and the owner of a project, including any successors, assigns or transferees, shall operate and maintain the project in a manner consistent with program requirements including, but not limited to its use for eligible occupants, for the term of the tax credits or twenty years, whichever is longer,

(2) If the title to a project transfers to the lending institution because of a foreclosure, a deed-in-lieu of foreclosure or an involuntary transfer under a bankruptcy proceeding, the lending institution may dispose of the property at its sole discretion.

Stat. Auth.: ORS 317.097
Stats. Implemented: ORS 317.097, 456.508, 456.510, 456.513, 456.559, 456.605 and 456.722
Hist.: OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-110-0040
Monitoring

(1) If the Department determines that the owner of a project under the OAHTC Program is not complying with any applicable rule, law, document or other OAHTC Program requirement, the Department may notify the lending institution, the owner and the sponsoring entity. In the notice, the Department will describe the matter of noncompliance, the required correction and the date by which correction must be made. The owner and sponsoring entity may comment on the notice within the period specified by the Department and submit any accompanying explanation and documentation.

(2) The owner of a project shall correct the noncompliance, if possible, and pay a penalty established by the Director for noncompliance under subsection (1) of this section and any further penalties assessed by the Department if the noncompliance is not corrected to the satisfaction of the Director within the period established by the Department. In assessing a penalty under this section, the Department shall take into consideration any comments submitted by the owner and sponsoring entity with respect to the noncompliance and their correction efforts, if any.

(3) Penalties assessed under this rule may not exceed three times the amount of the eligible tax credit per year.

(4) Any penalties assessed under this rule are the liability of the owner and not the liability of the lending institution.

Stat. Auth.: ORS 317.097
Stats. Implemented: ORS 317.097, 456.508, 456.510, 456.513, 456.559, 456.605, 456.722
Hist.: HSG 6-1991(Temp), f. & cert. ef. 11-5-91; HSG 3-1992, f. & cert. ef. 2-4-92; HSG 2-1995, f. & cert. ef. 9-25-95; OHCS 7-2006, f. & cert. ef. 5-17-06; OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-110-0045
Remedies

(1) If the Department determines that there has been any material failure or default with respect to any term, covenant or condition of the

applicable solicitation or fundingdocuments, applicable rules, directives, other program requirements, or otherwise, it (or as applicable, the Department of Revenue) may exercise any remedy available under OAR chapter 813 (including, but not limited to sanctions provided in OAR 813-110-0040, and remedies available in the OAHTC Manual and General Manual), relevant solicitation or funding documents, or applicable law. Remedies include, but are not limited to corrective orders or directives, sanctions, recapture of OAHTC, recovery for damages, specific performance, injunctive relief, declaratory actions, appointment of a receiver for the project, foreclosure of lien interests, debarment from other Department funding, and other remedies available at law.

(2) The remedies set forth in this section are cumulative and not exclusive and are in addition to any other rights and remedies provided in this Division, other Department rules, the solicitation or funding documents, or otherwise available at law or otherwise. The Department may exercise any or all remedies available to it, and in such manner as it, in its sole discretion, determines appropriate.

Stat. Auth.: ORS 314.097, 456.555
Stats. Implemented: ORS 317.097, 456.508, 456.510, 456.513, 456.559, 456.605 and 456.722
Hist.: OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-110-0050
Waiver

The Director may waive or modify any requirements of these Program rules, unless such waiver or modification would violate applicable state statute or federal regulations.

Stat. Auth.: ORS 317.097 & 456.515 - 456.720
Stats. Implemented: ORS 317.097
Hist.: OHCS 7-2006, f. & cert. ef. 5-17-06 Suspended by OHCS 9-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

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Rule Caption: Amends process for soliciting and administering funding awards for the Low-Income Housing Tax Credit Program
Adm. Order No.: OHCS 10-2013(Temp)
Filed with Sec. of State: 6-21-2013
Certified to be Effective: 6-21-13 thru 12-18-13
Notice Publication Date:
Rules Adopted: 813-090-0045, 813-090-0048, 813-090-0075, 813-090-0090, 813-090-0100
Rules Amended: 813-090-0005, 813-090-0010, 813-090-0015, 813-090-0035, 813-090-0037, 813-090-0039, 813-090-0040, 813-090-0067, 813-090-0080, 813-090-0095
Rules Suspended: 813-090-0027, 813-090-0031, 813-090-0036, 813-090-0065
Subject: The Low Income Housing Tax Credit Program assists and encourages the development of affordable multifamily housing development rental units through the allocation of housing tax credits. The department has completed a significant reorganization as to how it solicits and administers funding awards for this program as part of the restructure. These rule changes are designed to reflect the significant reorganization of the department.
Rules Coordinator: Sandy McDonnell—(503) 986-2012

813-090-0005
Purpose and Objectives

OAR chapter 813, division 90, is promulgated to carry out the provisions of the Low Income Housing Tax Credit ("LIHTC") Program The Program's purpose is to assist and encourage the development of affordable multifamily housing development rental units through the allocation of housing tax credits as provided in the Internal Revenue Code of 1986, as amended ("IRC"), Section 42. The Department has been designated as the housing tax credit allocating agency for the State of Oregon. Additional LIHTC Program policies and instructions are outlined in the LIHTC Program Policies and Guidelines Manual dated June 21, 2013 (the "LIHTC Manual" or "Manual"), incorporated herein by reference. The Manual may be accessed online on the Department's website.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 183 & 456.515 - 456.720
Stats. Implemented: ORS 456.559(1)(f)
Hist.: HSG 13-1987(Temp), f. & ef. 9-28-87; HSG 1-1988, f. & cert. ef. 3-8-88; HSG 3-1989(Temp), f. & cert. ef. 6-8-89; HSG 18-1989, f. & cert. ef. 11-3-89; HSG 12-1990(Temp), f. & cert. ef. 5-29-90; HSG 14-1990, f. & cert. ef. 10-26-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 7-1991, f. & cert. ef. 12-19-91; OHCS 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-090-0010
Definitions

Certain terms used in OAR chapter 813, division 90, are defined in the Act and OAR 813-005-0005. Other terms may be identified in the text of this division (including by incorporation), otherwise in chapter 813, IRC Section 42 or other applicable law.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 183 & 456.515 - 456.720
Stats. Implemented: ORS 456.559(1)(f)
Hist.: HSG 13-1987(Temp), f. & ef. 9-28-87; HSG 1-1988, f. & cert. ef. 3-8-88; HSG 3-1989(Temp), f. & cert. ef. 6-8-89; HSG 18-1989, f. & cert. ef. 11-3-89; HSG 12-1990(Temp), f. & cert. ef. 5-29-90; HSG 14-1990, f. & cert. ef. 10-26-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 7-1991, f. & cert. ef. 12-19-91; OHCS 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-090-0015
Allocation of Credit Authority

(1) Under the LIHTC Program, pursuant to the Department's statutory authority to assist and encourage the development of affordable housing rental units for low-income households, the Department allocates low-income housing tax credits ("LIHTC" or "tax credits") consistent with its relevant Qualified Allocation Plan ("QAP") and this Division (including the LIHTC Manual) by:

(a) Soliciting applications during specified periods within the Department's consolidated funding cycle through solicitation documents including, but not limited to a Notice of Funding Availability ("NOFA");

(b) Selecting projects to receive tax credit allocations from a pool of qualified applications; or

(c) Such other process as the Department determines to be appropriate.

(2) Tax credits are allocated only to qualified low-income multifamily rental housing development projects as defined in IRC Section 42(g). Dwelling units within each building of such projects that are constructed or rehabilitated with tax credits must be rent and income restricted in accordance with IRC Section 42.

(3) An award or allocation of tax credits made by the Department according to IRC Section 42(m) is subject to all of the following, as the following apply when the award is made:

(a) IRC Section 42, applicable regulations, legislative modification, and revenue procedures enacted or adopted thereunder by the Internal Revenue Service;

(b) ORS 456.559, and applicable rules including, but not limited to this Division;

(c) The QAP approved by the Governor and in effect at the time of the initial application; and

(d) Such other terms and conditions as the Department may require.

(4) The amount of tax credits that the Department may offer for a project depends upon:

(a) The amount of credits available under the state's bond volume cap;

(b) The amount of tax credits available under the applicable allocation process; and

(c) The appropriate level of tax credits for the specific project as determined by the Department.

(5) For the purpose of furthering development and rehabilitation of affordable housing in the state, the Department may offer and reserve the amount of tax credits for a given year and may include estimates of competitive annual authority amounts for future credit years.

(6) The Department maintains and publishes for each calendar year a record of tax credit awards and the ongoing balance of tax credits not yet awarded for the year. The record accounts separately for the credit authority set-aside required by OAR 813-090-0065.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.508, 456.510, 456.513, 456.559, 456.605, 456.626, 456.722
Hist.: HSG 13-1987(Temp), f. & ef. 9-28-87; HSG 1-1988, f. & cert. ef. 3-8-88; HSG 3-1989(Temp), f. & cert. ef. 6-8-89; HSG 18-1989, f. & cert. ef. 11-3-89; HSG 12-1990(Temp), f. & cert. ef. 5-29-90; HSG 14-1990, f. & cert. ef. 10-26-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 7-1991, f. & cert. ef. 12-19-91; OHCS 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-090-0027
Farmers Home Administration 515 Program Set Aside

(1) Ten percent of the Credit Authority for any calendar year may be set aside for Projects financed through the Farmers Home Administration (FmHA) 515 Program.

(2)(a) To qualify for Housing Credit set aside under OAR 813-090-0025(1), Applicants shall submit documentation from FmHA substantiating they are approved for financing under the FmHA 515 Program. A completed Form AD622, or its equivalent will be acceptable for this purpose if the

Form AD622 indicates that the project has been determined to be eligible for funding in competition with similar applications and the Applicant has been invited to file a formal application with FmHA in time to be funded by November 1st of the year from which Housing Credit will be allocated. The Department may revoke an offer of Housing Credit allocation to an FmHA 515 Project or terminate a Reservation and Extended Use Agreement under OAR 813-090-0060 if FmHA funding is not committed to by November 1st of the Housing Credit allocation year;

(b) If the full set aside is not allocated through an application process, other rural housing (as defined by FmHA rules) will have first priority for the balance of the set aside with any unused tax credit added to non-rural projects.

Stat. Auth.: ORS 183 & 456.515 - 456.720
Stats. Implemented: ORS 456.559(1)(f)
Hist.: HSG 13-1987(Temp), f. & ef. 9-28-87; HSG 1-1988, f. & cert. ef. 3-8-88; HSG 3-1989(Temp), f. & cert. ef. 6-8-89; HSG 18-1989, f. & cert. ef. 11-3-89; HSG 12-1990(Temp), f. & cert. ef. 5-29-90; HSG 14-1990, f. & cert. ef. 10-26-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 7-1991, f. & cert. ef. 12-19-91; Suspended by OHCS 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-090-0031
Application Requests and Charges

(1) The Department may solicit applications for an allocation of Housing Credit from interested parties when such credit is available.

(2) The Department may require a non-refundable application charge from any applicant requesting Low Income Housing Tax Credits through the Consolidated Funding Cycle or otherwise.

(3) The Department may require a supplemental application charge from applicants requesting additional resources for projects that have already been funded by the Department.

(4) The Department may require a transfer application charge from owners of projects that receive grants or tax credits through the Department, who request the Department's approval of a change in project ownership. The Department may assess a transfer review charge to project owners and transferees who effect a change in project ownership without prior written Department approval.

(5) The Department may require a reservation charge from any applicant prior to the execution of a Reservation and Extended Use Agreement.

(6) The Department may assess additional late charges to an applicant if its LIHTC final application is received by the Department after established deadlines. The Department also may assess a supplemental charge to an applicant if the Department determines that a re-evaluation of the applicant's final application is necessary or warranted.

(7) If the Housing Credits awarded to a project cannot be used by the end of the calendar year of the tax credit allocation and the owner has expended or incurred 10% of project costs, an application for a Carryover Allocation of Housing Credits must be made by the deadline established by the Department for the credit year or the credits will be lost. The Department may require a supplemental application charge from an applicant who submits an LIHTC carryover application after the deadlines established by the Department. The Department also may assess a supplemental charge to an applicant if the Department determines that a re-evaluation of the applicant's carryover application is necessary or warranted.

(8) The Carryover requirements do not apply to LIHTC projects using tax-exempt bond financing.

(9) The applicant shall submit an Application for final allocation of Housing Credits when the Project is placed in service. The Department shall prescribe the period for submitting a final Application. The Department may assess a late charge for applicants that submit Applications after the prescribed deadline. The Department also may assess a supplemental charge to an applicant if the Department determines that a re-evaluation of the applicant's final application is necessary or warranted.

(10) The Department may charge the Project owner reasonable charges for the Department's costs of monitoring the project owner's compliance with restrictions established by the Department and IRC Section 42 or applicable law.

(11) The Department shall evaluate completed applications based on a ranking system consistent with IRC Section 42(m)(l), established by the Department and set forth in the Department's qualified allocation plan.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 456.515 - 456.720
Stats. Implemented: ORS 456.559(1)(f)
Hist. HSG 12-1990(Temp), f. & cert. ef. 5-29-90; HSG 14-1990, f. & cert. ef. 10-26-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 7-1991, f. & cert. ef. 12-19-91; OHCS 9-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 8-2007, f. & cert. ef. 1-11-07; Suspended by OHCS 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-090-0035
Application for Tax Credits

(1) An entity legally doing business in Oregon and not subject to debarment or other exclusion by the Department or another state or federal agency may apply for a reservation of low-income housing tax credits as provided by this rule.

(2) An applicant for a tax credit project, also known in industry and Department usage as a "sponsor" of a project, must submit an application form for the credits on a form prescribed by the Department along with payment of the charge established by the Department for the application. The charge is nonrefundable. The information, in detail satisfactory to the Department, that an applicant must submit includes but is not limited to the following:

(a) Applicant and ownership information, including but not limited to entity names, addresses and contacts;

(b) Development team information;

(c) The amount and type of tax credits requested;

(d) The location of the project, including but not limited to street address, town, county, state, legislative districts, census tracts and legal description;

(e) Project and site characteristics, unit types, funding designations, project summaries, project's target population, market and rental studies or appraisals, and other pertinent project information as requested by the Department in its application form;

(f) The qualified basis as defined in IRC Section 42;

(g) The elections under IRC Section 42 that the owner of the proposed project has made or will make to qualify for an allocation of the tax credits, and when the housing units are projected to be placed in service;

(h) Complete financial projections about the proposed project, showing all sources, uses of funds and timelines for the uses of the funding sources;

(i) A projected operating pro forma statement on a cash flow basis, showing net operating income before debt service requirements, and the financial and economic premises used for the projections identified in the operating cash flow of the project;

(j) Evidence and a detailed summary of financing commitments, including but not limited to, proceeds or receipts to be generated by the sale of the tax credits or other tax benefits, construction and permanent loan financing, federal loan insurance and other substantial sources of funds;

(k) Other financial information regarding grants, subsidies, or tax-exempt financing for the proposed project and projections, assumptions or premises that support the project's long term viability within its initial and extended use period as an affordable housing development; and

(l) Such other information as the Department may require.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.508, 456.510, 456.513, 456.559, 456.605, 456.625, 456.722
Hist.: HSG 13-1987(Temp), f. & ef. 9-28-87; HSG 1-1988, f. & cert. ef. 3-8-88; HSG 3-1989(Temp), f. & cert. ef. 6-8-89; HSG 18-1989, f. & cert. ef. 11-3-89; HSG 12-1990(Temp), f. & cert. ef. 5-29-90; HSG 14-1990, f. & cert. ef. 10-26-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 7-1991, f. & cert. ef. 12-19-91; OHCS 9-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 8-2007, f. & cert. ef. 1-11-07; OHCS 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-090-0035
Application for Tax Credits

(1) An entity legally doing business in Oregon and not subject to debarment or other exclusion by the Department or another state or federal agency may apply for a reservation of low-income housing tax credits as provided by this rule.

(2) An applicant for a tax credit project, also known in industry and Department usage as a "sponsor" of a project, must submit an application form for the credits on a form prescribed by the Department along with payment of the charge established by the Department for the application. The charge is nonrefundable. The information, in detail satisfactory to the Department, that an applicant must submit includes but is not limited to the following:

(a) Applicant and ownership information, including but not limited to entity names, addresses and contacts;

(b) Development team information;

(c) The amount and type of tax credits requested;

(d) The location of the project, including but not limited to street address, town, county, state, legislative districts, census tracts and legal description;

(e) Project and site characteristics, unit types, funding designations, project summaries, project's target population, market and rental studies or appraisals, and other pertinent project information as requested by the Department in its application form;

(f) The qualified basis as defined in IRC Section 42;

(g) The elections under IRC Section 42 that the owner of the proposed project has made or will make to qualify for an allocation of the tax credits, and when the housing units are projected to be placed in service;

(h) Complete financial projections about the proposed project, showing all sources, uses of funds and timelines for the uses of the funding sources;

(i) A projected operating pro forma statement on a cash flow basis, showing net operating income before debt service requirements, and the financial and economic premises used for the projections identified in the operating cash flow of the project;

(j) Evidence and a detailed summary of financing commitments, including but not limited to, proceeds or receipts to be generated by the sale of the tax credits or other tax benefits, construction and permanent loan financing, federal loan insurance and other substantial sources of funds;

(k) Other financial information regarding grants, subsidies, or tax-exempt financing for the proposed project and projections, assumptions or premises that support the project's long term viability within its initial and extended use period as an affordable housing development; and

(l) Such other information as the Department may require.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 456.555

Stats. Implemented: ORS 456.508, 456.510, 456.513, 456.559, 456.605, 456.625, 456.722

Hist.: HSG 13-1987(Temp), f. & ef. 9-28-87; HSG 1-1988, f. & cert. ef. 3-8-88; HSG 3-1989(Temp), f. & cert. ef. 6-8-89; HSG 18-1989, f. & cert. ef. 11-3-89; HSG 12-1990(Temp), f. & cert. ef. 5-29-90; HSG 14-1990, f. & cert. ef. 10-26-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 7-1991, f. & cert. ef. 12-19-91; OHCS 9-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 8-2007, f. & cert. ef. 1-11-07; OHCS 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-090-0036

Procedures for Allocation of Low-Income Housing Tax Credit

(1) Applicants selected for an offer under OAR 813-090-0035 must execute with the Department a Reservation and Extended Use Agreement in a form satisfactory to the Department. The Reservation and Extended Use Agreement will include, among other things, a provision for financial evaluation of the Project based on cost certification and will incorporate a Declaration of Land Use Restrictive Covenants to be executed and recorded prior to the Department completing a Form 8609 and delivering a copy thereof to the Applicant.

(2) If the Housing Credit cannot be used in the year of allocation but the proposed Project is over 10 percent completed, a Carryover Allocation may be made. If a Carryover Allocation has been made, the owner shall submit the application for final allocation of Housing Credit when the Project is placed in service. The Department shall limit at the time of the extension of a Carryover Allocation, the maximum credit which the proposed project may receive.

(3) Upon receipt of a certified copy of the recorded Declaration of Land Use Restrictive Covenants in a form satisfactory to the Department, the Department shall complete and issue Part I of Internal Revenue Service Form 8609 to confirm final allocation of Housing Credits.

(4) The Project owner shall be responsible for filing the required IRS Form with his or her tax return.

(5) An allocation may not be rescinded or reduced by the Department except as provided under OAR 813-090-0060. Proposed Project owners may return unneeded Housing Credit by completing and filing with the Department, forms supplied by the Department.

Stat. Auth.: ORS 456.515 - 456.720

Stats. Implemented: ORS 456.559(1)(f)

Hist.: HSG 12-1990(Temp), f. & cert. ef. 5-29-90; HSG 14-1990, f. & cert. ef. 10-26-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 7-1991, f. & cert. ef. 12-19-91; OHCS 9-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 8-2007, f. & cert. ef. 1-11-07; Suspended by OHCS 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-090-0037

Evaluation of Applications

The Department's evaluation of applications for tax credits may involve actions including, but not limited to the following:

(1) Review of tax credit applications according to published criteria identified in any applicable solicitation documents, the applicable QAP, IRC Section 42, and this Division.

(2) Determination of financial feasibility of each project, based on the information provided in the application and confirmation of the need for the amount of tax credits requested for each project.

(3) Scoring and ranking of the applications pursuant to any applicable solicitation documents, IRC Section 42 and this Division as appropriate for each type of tax credits.

(4) Publication of applicable ranking of applications and successful awards of tax credits.

[Publications: Publications referenced are available from the agency.

Stat. Auth.: ORS 456.555

Stats. Implemented: ORS 456.508, 456.510, 456.513, 456.559, 456.605, 456.625, 456.722

Hist. HSG 12-1990(Temp), f. & cert. ef. 5-29-90; HSG 14-1990, f. & cert. ef. 10-26-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 7-1991, f. & cert. ef. 12-19-91; Renumbered from 813-090-0030, OHCS 5-2013, f. & cert. ef. 6-21-13; OHCS 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-090-0039

Reservation and Allocation; Extended Use Agreement; Carryover

(1) An applicant may receive a tax credit reservation commitment from the Department upon its determination to make an award to the applicant. An applicant qualifies for an allocation of tax credit when the Department determines that the applicant has satisfactorily accomplished all of the following:

(a) Executes with the Department a reservation and extended use agreement under this rule as provided and approved by the Department;

(b) Executed in favor of the Department and recorded at its own expense a declaration of land use restrictive covenants with respect to the project satisfactory to the Department;

(c) Paid all applicable charges imposed by the Department as the charges are invoiced; and

(d) Satisfied all other conditions that the Department may require.

(2) A reservation and extended use agreement (REUA") under this rule is a contract satisfactory to the Department between the proposed project owner and the Department in which the proposed project owner agrees, among other things, to construct or acquire and rehabilitate, as well as maintain the project in a safe, sanitary and otherwise habitable condition, maintain the project as affordable housing consistent with IRC Section 42, the Department's reservation commitment, applicable solicitation terms, this Division and state law. At a minimum, the REUA must include the following:

(a) A statement of the amount of the proposed tax credits to be reserved for the project, subject to later allocation;

(b) A provision for financial evaluation of the project based on timely cost certifications;

(c) The specifications of a minimum applicable unit fraction as defined by the IRC Section 42(c)(1)(B) and the rent formula to be maintained for the project to continue to qualify for the low-income housing tax credits;

(d) A commitment to meet the minimum applicable unit fraction and restricted rent requirements under subsection (c) of this section for an affordability period of a minimum of 30 years or the time period specified in the solicitation (whichever is longer) - composed of both the initial compliance period of 15 years and the extended use period comprising the balance of the affordability period, which latter period in no instance may be shorter than a minimum of an additional 15 years, in accordance with IRC Section 42;

(e) A provision that the REUA:

(A) Is enforceable in any state court by any individual who qualified for occupancy by virtue of the income limitation set for any building in the project to which the agreement applies; and

(B) Binds all successors of the applicant; and

(f) Such other terms and conditions as the Department may require including, but not limited to a reservation of right by the Department to modify, suspend, or waive requirements with respect to affordability (including restrictive covenants and equitable servitudes) beyond the 15-year compliance period at its sole discretion.

(3) Not later than the deadline established by the Department for the credit year, an applicant who executes with the Department an REUA with respect to competitive authority tax credits under section (1) of this rule and is not yet eligible to receive its final allocation determination through issuance of Internal Revenue Service Form 8609, must apply for a carryover allocation of the tax credits or forfeit the reserved credits. A project only qualifies for a carryover allocation of the tax credits if the project sponsor has expended or is expected to expend at least ten percent or more of its total project costs within 12 months from the date the carryover allocation is made, and if the expenditure or expected expenditure is substantiated to the Department's satisfaction by a cost certification completed by a third party accounting professional.

(4) If an applicant fails to make a carryover application as required by section (3) of this section:

(a) The project owner forfeits the entirety of the tax credits reservation; and

(b) Any associated charges paid by the project owner are not refundable.

(5) The maximum amount of tax credits that a project may receive under a carryover allocation is the amount of tax credits determined by the Department to make the project financially feasible.

(6) A project owner who has obtained a carryover allocation must submit an application for final allocation determination and request issuance of Internal Revenue Service Form 8609 by the deadline established by the Department once the project owner places the project in service. The project owner must also pay any appropriate charges as requested by the Department, including but not limited to any supplemental charges the Department determines as a result of additional evaluations of multiple or incomplete final application submissions for the same project, and a late charge if the project owner files the application after the final application deadline.

(7) An applicant must execute and record a declaration of land use restrictive covenants ("Declaration") and other funding documents satisfactory to the Department in the official records of all counties in which the project is sited and in such priority of title as the Department may require. The applicant also must timely deliver to the Department a certified copy of the recorded Declaration, as recorded in each county. The Declaration must, among other terms and conditions satisfactory to the Department, include a commitment by the owner of the project to meet the applicable fraction and restricted rent requirements for the entire affordability period described in the Declaration, including the initial compliance period of 15 years and the applicable extended use period, the latter of which must be for a minimum of an additional 15 years, in accordance with IRC Section 42 and Department requirements.

(8) The requirement of a carryover application under this section does not apply to a low-income housing tax credit project that uses tax-exempt bond financing.

[Publications: Publications referenced are available from the agency.
Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.508, 456.510, 456.513, 456.559, 456.605, 456.625, 456.722
Hist.: HSG 14-1990, f. & cert. ef. 10-26-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 7-1991, f. & cert. ef. 12-19-91; Renumbered from 813-090-0029, OHCS 5-2013, f. & cert. ef. 6-21-13; OHCS 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-090-0040
Reservations and Allocations Subject to State Housing Council Approval

If the Department provides a reservation or an allocation of LIHTC under this Division and if the amount of any related tax credits or any other Department funding approved by the Department that was considered by the Department in setting the amount of the tax credits ("Complementary Funding") meets or exceeds the threshold amount established in OAR 813-001-0007(1) for review by the State Housing Council, the reservation or allocation commitment is subject to review and approval by the Council of such tax credit assistance and any such Complementary Funding. The Council may approve, deny, modify or further condition funding assistance subject to its review. Based upon any relevant Council determination, including with respect to Complementary Funding, any subject reservation or allocation may be deemed revoked, or be modified and further conditioned.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.508, 456.510, 456.513, 456.559, 456.605, 456.625, 456.722
Hist.: HSG 13-1987(Temp), f. & ef. 9-28-87; HSG 1-1988, f. & cert. ef. 3-8-88; HSG 3-1989(Temp), f. & cert. ef. 6-8-89; HSG 18-1989, f. & cert. ef. 11-3-89; HSG 12-1990(Temp), f. & cert. ef. 5-29-90; HSG 14-1990, f. & cert. ef. 10-26-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 7-1991, f. & cert. ef. 12-19-91; OHCS 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-090-0045
Final Allocation

After the Department has received certified copies of the relevant recorded declarations of restrictive covenants as required by OAR 813-090-0039, the Department will issue to the owner of the project Part I of Internal Revenue Service Form 8609 to confirm the final allocation of the tax credits for the project. No allocation of tax credits is binding until the Department has issued Part I of Internal Revenue Service Form 8609 under this rule. Any allocation of tax credits remains subject to recapture by the IRS for noncompliance with any of the terms or conditions upon which the allocation was predicated.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.508, 456.510, 456.513, 456.559, 456.605, 456.625, 456.722
Hist.: OHCS 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-090-0048
Amount of Tax Credits

The Department's determination of the amount of tax credits for a project may not exceed the amount necessary for the financial feasibility of the units of the project that are represented by the applicable fraction at the restricted rents specified in the agreement under OAR 813-090-0039. The amount of low-income housing tax credits available for allocation to a project is the amount that the Department determines is necessary to make the project financially feasible, but not exceeding the applicable percentage of the qualified basis of each qualified low-income building in the project.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.508, 456.510, 456.513, 456.559, 456.605, 456.625, 456.722
Hist.: OHCS 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-090-0065
Representations

The Department shall rely on representations of the Applicant, including all agents and parties of interest, in reviewing applications and evaluating the amount of Housing Credit needed and whether a proposed Project qualifies for a Housing Credit allocation, and shall not validate the financial feasibility of a proposed or established Project, credit worthiness of the Applicant, or tax consequences of the Housing Credit for the Project, the Applicant or any other interested party.

Stat. Auth.: ORS 456.515 - 456.720
Stats. Implemented: ORS 456.559(1)(f)
Hist.: HSG 12-1990(Temp), f. & cert. ef. 5-29-90; HSG 14-1990, f. & cert. ef. 10-26-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 7-1991, f. & cert. ef. 12-19-91; Suspended by OHCS 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-090-0067
Set Aside

The Department will set aside ten percent of the amount of its annual competitive tax credit authority issued by the IRS for making reservations to applicants appropriately involving the participation of a not-for-profit entity in the development or operation, or both, of a qualifying project.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.508, 456.510, 456.513, 456.559, 456.605, 456.625, 456.722
Hist.: HSG 13-1987(Temp), f. & ef. 9-28-87; HSG 1-1988, f. & cert. ef. 3-8-88; HSG 3-1989(Temp), f. & cert. ef. 6-8-89; HSG 18-1989, f. & cert. ef. 11-3-89; HSG 12-1990(Temp), f. & cert. ef. 5-29-90; HSG 14-1990, f. & cert. ef. 10-26-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 7-1991, f. & cert. ef. 12-19-91; Renumbered from 813-090-0025, OHCS 5-2013, f. & cert. ef. 6-21-13; OHCS 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-090-0075
Purpose, Scope and Effect of Application Review; Tax Form Filing Responsibility

(1) When the Department reviews, evaluates and determines the qualifications of a proposed project for tax credits, the Department:

(a) Relies on representations made by the applicant in the application, including representations made by all agents, professionals and parties of interest;

(b) Makes no statement or representation of validity as to the financial feasibility of a proposed or established project, in whole or in part;

(c) Makes no statement or representations as to the credit worthiness of the applicant or any tax benefits or consequences that may or may not result from the use of low-income housing tax credits with respect to the project, the applicant or any other interested or affected party, including but not limited to present or future tenants; and

(d) Accepts no liability with respect to the accuracy of the application, the credit worthiness of the applicant, the efficacy of the allocation, or any tax benefits or consequences that may or may not result from the use of the allocated low-income housing tax credits with respect to the project, the applicant or any other interested or affected party, including but not limited to present or future tenants;

(2) In accepting a reservation or allocation of tax credits under this Division, the applicant expressly waives any claims against the Department with respect to the efficacy of the allocation, or any tax benefits or consequences that may or may not result from the use of the allocated low-income housing tax credits with respect to the project, the applicant or any other interested or affected party, including but not limited to present or future tenants.

(3) The Department has no responsibility for filing with the Internal Revenue Service any form that is required of a project owner.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.508, 456.510, 456.513, 456.559, 456.605, 456.625, 456.722
Hist.: OHCS 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-090-0080
Denial, Rescission, Reduction, Revocation of Tax Credits; Return of Excess

(1) The Department may deny an application for or revoke a reservation or allocation of tax credits made under this Division, terminate a relevant REUA, and take other action as it determines appropriate if the Department determines that:

(a) The project owner does not have site control or will not be able to obtain a construction loan or building permit or close its equity agreement for the proposed project in such a manner as to allow the completion of the project within the requirements of IRC Section 42;

(b) The proposed project will not be placed in service in accordance with the requirements of IRC Section 42;

(c) The proposed project financing is not committed to the project as represented in the application;

(d) The applicant has supplied inaccurate or misleading information;

(e) The applicant or project owner violates any material term of the applicable solicitation, applicable Department rules or directives, IRC Section 42, related regulations, the REUA, the Declaration or other funding documents; or

(f) Other circumstances warrant such action.

(2) The Department may reduce the amount of the tax credits identified in the agreement under OAR 813-090-0039 before the Department issues a carryover allocation or Form 8609 to the project owner if the Department determines that the project requires a lesser amount of tax credits than previously reserved for the project to be financially feasible during the affordability period.

(3) Once the Department has issued a carryover allocation under OAR 813-090-0039, the Department may reduce the allocation amount identified in the carryover allocation before delivering Part 1 of Internal Revenue Service Form 8609 to the project owner if the Department determines that the project requires a lesser amount of tax credits than previously allocated to the project to be financially feasible during the affordability period.

(4) The Department may revoke a carryover allocation if the Department determines one or more of the following:

(a) That at least 10% of the total project cost will not be expended in accordance with the carryover requirements in IRC Section 24;

(b) That the project will not be placed in service within two years following the calendar year in which a carryover allocation is made in accordance with the requirements of IRC Section 42; or

(c) That the project otherwise does not qualify for the carryover allocation.

(5) The owner of a proposed project may return excess tax credits to the Department by filing with the Department a final application or other form prescribed by the Department for the purpose of this section.

Stat. Auth.: ORS 456.555

Stats. Implemented: ORS 456.508, 456.510, 456.513, 456.559, 456.605, 456.625, 456.722

Hist.: HSG 13-1987(Temp), f. & ef. 9-28-87; HSG 1-1988, f. & cert. ef. 3-8-88; HSG 3-1989(Temp), f. & cert. ef. 6-8-89; HSG 18-1989, f. & cert. ef. 11-3-89; HSG 12-1990(Temp), f. & cert. ef. 5-29-90; HSG 14-1990, f. & cert. ef. 10-26-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 7-1991, f. & cert. ef. 12-19-91; Renumbered from 813-090-0060, OHCS 5-2013, f. & cert. ef. 6-21-13; OHCS 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-090-0090

Transfer of Owner, Tax Credit or Project Ownership

(1) The sponsor of a project to which low-income housing tax credits are allocated under the Low-Income Housing Tax Credit Program and an owner of such project may not transfer or allow any transfer of any interest in itself, the tax credits or the project or otherwise encumber the project, or any portion or interest therein, unless the Department first approves the transfer or encumbrance in writing. Any such transfer or encumbrance is subject to payment to the Department by the sponsor or owner of a transfer or encumbrance charge as required by the Department. If the sponsor or owner effects or allows a transfer or encumbrance without prior written approval by the Department, the transfer or encumbrance is voidable and remains subject to the approval or disapproval of the Department and the sponsor or owner and transferees, jointly and severally, are subject to a transfer or encumbrance review charge by the Department.

(2) The Department may condition its approval upon such terms and conditions as it, in its sole discretion, may require. Factors the Department may consider in determining whether to give approval to a transfer or encumbrance include but are not limited to:

(a) The financial investment of the Department in the project;

(b) Preservation of existing housing;

(c) The proposed transferee's ability to maintain and manage the project property for the needs of the residents, the integrity of the housing and as security for any financing;

(d) The effect of the transfer or encumbrance upon the financial integrity of the project, the tax credits, the repayment of project financing, use of the project for its intended purposes, and continuity of the program; and

(e) Continued compliance with applicable program requirements including, but not limited to terms and conditions of applicable funding documents, resultant restrictive covenants and equitable servitudes, and state and federal laws, rules and regulations.

Stat. Auth.: ORS 456.555

Stats. Implemented: ORS 456.508, 456.510, 456.513, 456.559, 456.605, 456.625, 456.722

Hist.: OHCS 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-090-0095

Monitoring and Compliance

(1) The Department will notify the Internal Revenue Service in writing when the Department determines that a project is not complying with applicable provisions of IRC Section 42. The Department is not liable to the project or project owner for any adverse consequences resulting from the Department's notification.

(2) The Department will send to the project owner a copy of the Department's notification of noncompliance to the Internal Revenue Service regarding the project.

(3) A project owner shall submit such information and documents, including but not limited to an annual report to the Department when the Department so requires for monitoring compliance.

(4) The Department may inspect the project and inspect and copy project records as it deems appropriate. The project owner will fully cooperate in such inspections.

(5) The program requirements including, but not limited to the terms and conditions of the REUA, Declaration and other funding documents, resultant restrictive covenants and equitable servitudes, and applicable state and federal laws, rules and regulations are subject to enforcement by the Department or its designees as they may determine appropriate, including but not limited to any failure by the project owner to timely satisfy any such program requirements.

(6) The REUA and Declaration are enforceable, according to their terms, by one or more tenants as third-party beneficiaries.

(7) The Department or one or more tenants or beneficiaries may recover legal costs, including reasonable legal charges and court and appeal costs, when the legal costs are incurred because of failure by the project owner to satisfy any of the terms or conditions of the REUA, Declaration, other funding documents or resultant restrictive covenants and equitable servitudes. The Department also may recover its reasonable legal fees and costs as otherwise provided in relevant documents or applicable law.

(8) The Department may charge the project owner for reasonable costs of administration including, but not limited to monitoring and enforcing the project owner's compliance with program requirements or other applicable law.

(9) The Department reserves the right, consistent with applicable law, to waive, modify and release REUA, Declaration and other funding documents terms and conditions including, but not limited to restrictive covenants and equitable servitudes related thereto. Any waiver, modification, or release must be in writing and signed by an authorized Department representative.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 456.555

Stats. Implemented: ORS 456.508, 456.510, 456.513, 456.559, 456.605, 456.625, 456.722

Hist.: HSG 12-1990(Temp), f. & cert. ef. 5-29-90; HSG 14-1990, f. & cert. ef. 10-26-90; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 7-1991, f. & cert. ef. 12-19-91; OHCS 9-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 8-2007, f. & cert. ef. 1-11-07; Renumbered from 813-090-0095, OHCS 5-2013, f. & cert. ef. 6-21-13; OHCS 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-090-0100

Remedies

(1) If the Department determines that there has been any material failure or default with respect to any term, covenant or condition of the applicable solicitation or funding documents, applicable rules, directives, other program requirements, or otherwise, it (or as applicable, the IRS) may exercise any remedy available under OAR chapter 813 (including remedies available in the LIHTC Manual and General Manual), relevant solicitation or funding documents, or applicable law. Remedies include, but are not limited to corrective orders or directives, recapture of LIHTC, recovery for damages, specific performance, injunctive relief, declaratory actions, appointment of a receiver for the project, foreclosure of lien interests, debarment from other Department funding, and other remedies available at law.

(2) The remedies set forth in this section are cumulative and not exclusive and are in addition to any other rights and remedies provided in this Division, other Department rules, the solicitation and funding documents, or otherwise available at law or otherwise. The Department may exercise any or all remedies available to it, and in such manner as it, in its sole discretion, determines appropriate.

Stat. Auth.: ORS 456.555

Stats. Implemented: ORS 456.508, 456.510, 456.513, 456.559, 456.605, 456.625, 456.722

Hist.: OHCS 10-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

Rule Caption: Amends the process for soliciting and administering funding awards for the HOME Investment Partnerships Program
Adm. Order No.: OHCS 11-2013(Temp)
Filed with Sec. of State: 6-21-2013
Certified to be Effective: 6-21-13 thru 12-18-13
Notice Publication Date:
Rules Adopted: 813-120-0015, 813-120-0142
Rules Amended: 813-120-0001, 813-120-0010, 813-120-0025, 813-120-0032, 813-120-0035, 813-120-0045, 813-120-0047, 813-120-0050, 813-120-0110, 813-120-0120, 813-120-0130
Rules Suspended: 813-120-0020, 813-120-0040, 813-120-0060, 813-120-0140
Subject: The HOME Investment Partnerships Program provides funds to construct or acquire and rehabilitate affordable multifamily rental housing for families of low and very low income, provides tenant-based rental assistance for individuals and families of low and very low income, and leverages local and private monies available from other sources for the purpose of developing appropriate low income and very low income multifamily rental housing. The department has completed a significant reorganization as to how it solicits and administers funding awards for this program as part of the restructure. These rule changes are designed to reflect the significant reorganization of the department.
Rules Coordinator: Sandy McDonnell—(503) 986-2012

813-120-0001
Purpose and Objectives

(1) OAR chapter 813, division 120, is promulgated to assist the Department in carrying out the HOME Investment Partnerships (HOME) Program in Oregon. The U.S. Department of Housing and Urban Development (HUD), pursuant to 24 CFR 92, has designated the Housing and Community Services Department as a participating jurisdiction upon approving Oregon's Consolidated Plan, which is the State of Oregon's plan describing the needs, resources, priorities and proposed activities to be undertaken with respect to the HUD HOME Program in this state. Under the Consolidated Plan, the needs, resources, priorities and proposed activities of the HOME Program in this state are as follows:

(a) To provide funds to construct or acquire and rehabilitate affordable multifamily rental housing for families of low and very low income;

(b) To provide tenant-based rental assistance for individuals and families of low- and very low-income; and

(c) To leverage local and private monies available from other sources for the purpose of developing appropriate low income and very low income multifamily rental housing.

(2) Additional HOME Program policies and instructions are outlined in the HOME Program Policies and Guidelines Manual dated June 21, 2013 (The "HOME Manual" or "Manual") incorporated herein by reference. The Manual may be accessed online on the Department's website.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 456.555, 456.620
Stats. Implemented: ORS 456.559, 456.620
Hist.: HSG 6-1992(Temp), f. & cert. ef. 6-15-92; HSG 10-1992, f. & cert. ef. 11-20-92; HSG 1-1993(Temp), f. & cert. ef. 2-19-93; HSG 3-1993, f. & cert. ef. 8-18-93; HSG 8-1994, f. & cert. ef. 9-9-94; HSG 3-1995, f. & cert. ef. 9-25-95; OHCS 1-2008, f. & cert. ef. 1-28-08; OHCS 11-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-120-0010
Definitions

(1) The definitions of terms in 24 CFR 92.2 govern the use of those terms in OAR chapter 813, division 120. The terms include but are not limited to "commitment," "Consolidated Plan," "project completion," "state recipient," "subrecipient" and "tenant-based rental assistance."

(2) In OAR chapter 813, Division 120:

(a) "Community housing development organization" has the meaning given that term in 24 CFR 92.2, but with the limitation that a community housing development organization must be currently registered with the Oregon Secretary of State.

(b) "Recipient" means any entity under contract with the Department to undertake activities funded by the HOME Investment Partnerships Program.

(c) A "For-profit organization" means an individually- or cooperatively-owned organization for profit incorporated under or subject to the provisions of ORS Chapter 60 that is not a foreign corporation.

(d) A "Nonprofit organization" means any of the following:

(A) An organization that is established under ORS chapter 65;

(B) A community development corporation as defined in ORS 458.210;

(C) A housing authority as defined in 456.005;

(D) A community action agency as established by the Economic Opportunity Act of 1964 and under ORS 458.505; or

(E) Any other nonprofit entity, including an office, division or agency of a political subdivision, that represents or seeks to serve the housing, human services and community economic revitalization needs of a clearly-defined population and area.

(3) Certain other terms used in OAR chapter 813, Division 120, are defined in the Act, OAR 813-005-0005, or herein (including by incorporation).

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 456.555, 456.620
Stats. Implemented: ORS 456.559, 456.620
Hist.: HSG 6-1992(Temp), f. & cert. ef. 6-15-92; HSG 10-1992, f. & cert. ef. 11-20-92; HSG 1-1993(Temp), f. & cert. ef. 2-19-93; HSG 3-1993, f. & cert. ef. 8-18-93; HSG 8-1994, f. & cert. ef. 9-9-94; HSG 3-1995, f. & cert. ef. 9-25-95; HSG 1-1997, f. & cert. ef. 4-15-97; OHCS 1-2008, f. & cert. ef. 1-28-08; OHCS 11-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-120-0015
Initiation of Funding

Department funding assistance under the HOME Program may be initiated by the Department consistent with OAR chapter 813 pursuant to relevant solicitation documents including, but not limited to a Notice of Funding Availability (NOFA), or as otherwise determined by the Department.

Stat. Auth.: ORS 456.555, 456.620
Stats. Implemented: ORS 456.559, 456.620
Hist.: ; OHCS 11-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-120-0020
Eligible Applicants

Eligible Applicants for HOME funds include:

(1) Units of general local government, For-Profit and Nonprofit Organizations, and individuals to construct new housing for Low- and Very Low-Income Families, or to acquire and/or rehabilitate existing housing for Low- and Very Low-Income Families, or to sponsor local programs to construct, acquire or rehabilitate housing owned and occupied by Low- and Very Low-Income Families;

(2) Local Partnership Programs and other approved agencies to provide Tenant-Based Rental Assistance to qualified Low- and Very Low-Income Families;

(3) CHDOs to provide funds for the construction of housing for rental and Homeownership opportunities by Low- and Very Low-Income Families, or to acquire and/or rehabilitate existing structures for rental and Homeownership opportunities by Low- and Very Low-Income Families.

(a) The Department shall set aside 15 percent of the HOME allocation for housing developed, owned or sponsored by CHDOs.

(b) The CHDO set-aside may also include Project-specific predevelopment and technical assistance loans.

Stat. Auth.: ORS 456.620
Stats. Implemented: ORS 456.559(1)(f)
Hist.: HSG 6-1992(Temp), f. & cert. ef. 6-15-92; HSG 10-1992, f. & cert. ef. 11-20-92; HSG 1-1993(Temp), f. & cert. ef. 2-19-93; HSG 3-1993, f. & cert. ef. 8-18-93; HSG 8-1994, f. & cert. ef. 9-9-94; HSG 3-1995, f. &n cert. ef. 9-25-95; HSG 1-1997, f. & cert. ef. 4-15-97; OHCS 1-2008, f. & cert. ef. 1-28-08; Suspended by OHCS 11-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-120-0025
Application Procedure and Requirements

(1) The process to obtain HOME assistance typically will be spelled out in the solicitation documents issued by the Department. In addition to, or in lieu of formal solicitation documents, the Department may provide other means for accessing HOME assistance consistent with 24 CFR 92 (as administered by HUD) and these rules. Additional direction and guidance may be found in the HOME Manual and General Manual.

(2) The Department may refuse to process applications or terminate processing if it determines an application to be incomplete or that it fails to satisfy threshold standards for further processing.

(3) An applicant shall submit to the Department, on the application form and in accordance with the application process prescribed by the Department, such information as the Department may require, including but not limited to:

(a) Name, address and telephone number of applicant;

(b) Type of assistance requested;

(c) A written description of the project, including the number of units, unit mix, proposed rents, site location, amenities, and any other information requested by the Department.

(d) A statement of project purpose indicating the housing type and residents to be housed, and the length of the affordability period;

(e) A pro forma of project income and expenses;

(f) The amount of funding requested and total project development costs, including a description and documentation of all project funding sources and uses;

(g) A narrative of the applicant's experience in developing affordable housing, including the experience of all members of the project development team;

(h) A narrative of the experience of the applicant's management team or agent as it relates to operating affordable housing projects;

(i) A description of resident services, if any, to be provided;

(j) A narrative of the applicant's experience in providing resident services, including the experience of any relevant project team members;

(k) A description of the applicant's readiness to proceed with project activities; and

(l) A schedule for completion of project activities.

(4) The Department may restrict the amount and/or type of assistance available in any solicitation or other provision of assistance and restrict the type or number of applicants or recipients eligible for assistance in a particular funding process.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 456.620
Stats. Implemented: ORS 456.559(1)(f)
Hist.: HSG 6-1992(Temp), f. & cert. ef. 6-15-92; HSG 10-1992, f. & cert. ef. 11-20-92; HSG 1-1993(Temp), f. & cert. ef. 2-19-93; HSG 3-1993, f. & cert. ef. 8-18-93; HSG 8-1994, f. & cert. ef. 9-9-94; HSG 3-1995, f. & cert. ef. 9-25-95; HSG 1-1997, f. & cert. ef. 4-15-97; OHCS 9-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 10-2007, f. & cert. ef. 1-11-07; OHCS 1-2008, f. & cert. ef. 1-28-08; Renumbered from 813-120-0080, OHCS 6-2013, f. & cert. ef. 6-21-13; OHCS 11-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-120-0032
Application Review

(1) An application for assistance from the HOME program is subject to the Department's evaluation and approval or disapproval or modification according to criteria in the solicitation documents or otherwise that may include, but are not limited to the following:

(a) The amount of available funds in the HOME Program;

(b) The availability of other sources of assistance;

(c) The applicant's efforts to leverage other public or private funds;

(d) Whether the project is financially feasible and the financial strength and history of the prospective recipient;

(e) The location of the project site, including its proximity to transportation, shopping, social, commercial and recreational facilities, medical services and such other facilities and services that best serve the residents;

(f) Availability of street, sewer, water, utilities and other public services;

(g) Architectural design, including aesthetic quality, soundness of construction, energy efficiency, and suitability to the needs of the residents to be served;

(h) Whether or not the project will include fee ownership of the real property;

(i) Compliance with the Consolidated Plan, applicable local comprehensive plan, land use regulations, housing codes and other applicable standards;

(j) Market demand;

(k) The target population to be served;

(l) The experience of the developer, contractors, architects, consultants and management agent in developing, constructing and operating housing projects;

(m) The Department's experience with and the experience, capacity and legal history and status of the applicant and its agents, representatives, employees and contractors;

(n) Whether the project in comparison to others best achieves the purposes of the HOME Program;

(o) Whether the project is located within the geographical boundaries of the State's jurisdiction;

(p) The requirements of 24 CFR Part 92 and all other applicable federal cross-cutting regulations and federal statutes; and

(q) Other factors that the Department determines to be relevant including, but not limited to any evaluation criteria in the solicitation documents, HOME Manual, General Manual, or otherwise.

(2) If the Department approves an application in whole or in part and if the amount of the HOME assistance or any other Department funding approved by the Department that was considered by the Department in setting the amount of HOME assistance to be provided ("Complementary Funding") meets or exceeds the threshold amount established in OAR 813-001-0007(1) for review by the State Housing Council, the approval of HOME assistance by the Department is subject to review and approval by the Council of such HOME funding and any such Complementary Funding. The Council may approve, deny, modify or further condition funding subject to its review. Based upon any relevant Council determination, including with respect to Complementary Funding, approval of HOME funding may be deemed revoked, or be modified and further conditioned.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 456.555, 456.620
Stats. Implemented: ORS 456.559, 456.620, 456.625
Hist.: HSG 6-1992(Temp), f. & cert. ef. 6-15-92; HSG 10-1992, f. & cert. ef. 11-20-92; HSG 1-1993(Temp), f. & cert. ef. 2-19-93; HSG 3-1993, f. & cert. ef. 8-18-93; HSG 8-1994, f. & cert. ef. 9-9-94; HSG 3-1995, f. & cert. ef. 9-25-95; OHCS 1-2008, f. & cert. ef. 1-28-08: Renumbered from 813-120-0090, OHCS 6-2013, f. & cert. ef. 6-21-13; OHCS 11-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-120-0035
Form of Assistance; Documentation

(1) The Department may provide HOME funds in the form of a grant or a loan, or a combination of both. Loan rates and terms, if applicable shall be determined by the Department based on a project's needs and cash flow, other funding resources, market conditions and an applicant's capacity to repay HOME funds. The Department normally will notify an applicant in a written reservation letter as to the amount and form of HOME assistance, if any, to be provided, together with notable conditions. Such reservation commitments remain subject to Department rules, solicitation requirements, applicable law, and the negotiation, execution and recording (if required) of documents satisfactory to the Department.

(2) Each recipient shall, inter alia, execute a use agreement, containing such terms regarding interest rates, repayment terms, performance criteria, reporting requirements, restrictive covenants, and other terms as the Department or HUD considers appropriate or necessary for the type and use of assistance provided. Each use agreement must be:

(a) (If the recipient owns the project property at the time of disbursement) recorded as an encumbrance on the project property before any HOME funds are advanced; or

(b) (If the recipient does not own the project property at the time of disbursement) at the discretion of the Department, placed in escrow in an escrow account established by the recipient satisfactory to the Department and subject to such further conditions as the Department may require, including the recording of restrictive covenants running with the project property for the applicable affordability period with appropriate lien priority and taking effect upon close of escrow.

(3) The Department may require a recipient to execute and record such documents satisfactory to the Department as it considers appropriate in its sole discretion.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 456.555, 456.620
Stats. Implemented: ORS 456.559, 456.620
Hist.: HSG 6-1992(Temp), f. & cert. ef. 6-15-92; HSG 10-1992, f. & cert. ef. 11-20-92; HSG 1-1993(Temp), f. & cert. ef. 2-19-93; HSG 3-1993, f. & cert. ef. 8-18-93; OHCS 10-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 10-2007, f. & cert. ef. 1-11-07; Renumbered from 813-120-0100, OHCS 1-2008, f. & cert. ef. 1-28-08; OHCS 11-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-120-0040
Eligible Costs for HOME Activities

Costs are determined as eligible to be paid with HOME funds to the extent that they promote housing affordability. Eligible costs include:

(1) Development hard costs such as the actual costs of constructing or rehabilitating housing including, but not limited to:

(a) For new construction, costs to meet the applicable new construction standards of Oregon and the Model Energy Code referred to in 24 C.F.R. § 92.251.

(b) For rehabilitation, costs to meet the property standards in 24 C.F.R. § 92.251; to make essential improvements, including energy-related repairs or improvements, improvements necessary to permit use by persons with disabilities, the abatement of lead-based paint hazards, as required by 24 C.F.R. § 92.355, and to repair or replace major housing systems in danger of failure; costs to refinance existing debt when rehabilitating owner-occupied single family units;

(c) For both new construction and rehabilitation,

(A) Costs to make utility connections; and costs of existing structure demolition and improvements to the Project site. A Project shall be documented to have complied with these standards prior to the submission of an IDIS Project Completion Report.

(B) Costs associated with Project site improvements. Site improvements shall be comparable to those found in similar developments in the geographic area surrounding the Project and shall be accomplished for the primary use of the proposed Project residents.

(2) Development soft costs incurred by the owner and/or sponsor. These costs include reasonable and necessary costs associated with financing and/or development of new construction, rehabilitation, or acquisition including, but not limited to:

(a) Architectural, engineering and/or related professional services required for preparing plans, drawings, specifications or work write-ups;

(b) Costs to process and settle Project financing, including private lender origination fees, credit reports, fees for title evidence, legal document recording, attorneys, private appraisal, building permits, and independent cost estimate, builder or developer fees;

(c) Costs of a Project audit.

(d) Costs associated with services provided in connection with affirmative marketing and fair housing information, in conformance with 24 C.F.R. Part 92.

(e) For new construction or rehabilitation, the cost of funding an initial operating deficit reserve, and costs for the payment of impact fees that are charged for all developments within a jurisdiction.

(3) Costs of acquiring improved or unimproved real property, including acquisition by homebuyers.

(4) Costs of relocation payments and other related assistance for permanently or temporarily Displaced Persons, families, businesses, farm operations or other entities determined appropriate by the Department, and staff and overhead costs directly related to providing advisory and other relocation services.

(5) Costs of rent or rental deposits for tenants receiving HOME Tenant-Based Rental Assistance.

(6) Costs of Program administration up to ten percent (10%) of the Department's fiscal year allocation. Allowable Administrative Costs include, but are not limited to, activities involving the coordination, monitoring and evaluation of HOME-assisted Projects or Programs such as preparing budgets, schedules and amendments; evaluating Program results against stated objectives; developing systems for assuring compliance with Program requirements; monitoring Program activities for progress and compliance with Program requirements; preparing reports and other compliance documents related to the HOME Program; and coordinating the resolution of audit and monitoring findings; the Department's staff and overhead costs directly related to carrying out the Project.

(7) Project-specific technical assistance and site control loans, and Project-specific seed money loans to CHDOs as outlined in 24 C.F.R. § 92.301.

(8) Up to five percent (5%) of the Department's fiscal year HOME allocation may be used for the operating expenses of CHDOs as outlined in 24 C.F.R., Part 92.208.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 456.620
Stats. Implemented: ORS 456.559(1)(f)
Hist.: HSG 6-1992(Temp), f. & cert. ef. 6-15-92; HSG 10-1992, f. & cert. ef. 11-20-92; HSG 1-1993(Temp), f. & cert. ef. 2-19-93; HSG 3-1993, f. & cert. ef. 8-18-93; HSG 8-1994, f. & cert. ef. 9-9-94; HSG 3-1995, f. & cert. ef. 9-25-95; HSG 1-1997, f. & cert. ef. 4-15-97; OHCS 1-2008, f. & cert. ef. 1-28-08; Suspended by OHCS 11-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-120-0045
Eligible Activities

(1) The categories of activities for which the Department may provide funding under the HOME Program, subject to the Consolidated Plan, are those categories that are authorized in 24 CFR Part 92 and designated to the Department, including the following:

(a) Homeowner rehabilitation: For rehabilitation of single-family housing that is the principal residence of a homeowner whose family is a low-income or very low income family at the time of commitment by the Department of HOME funds. A homeowner rehabilitation program must be administered by a subrecipient.

(b) Homebuyer assistance: For acquisition, rehabilitation or construction, or any combination thereof, of housing to be owned and occupied by low- or very income low income families.

(c) Rental rehabilitation: For acquisition or rehabilitation, or both of existing structures for rental housing affordable to low-income and very-low-income families. The initial and long-term affordability requirements in OAR 813-120-0050 apply to rental housing assisted with HOME funds. A rental rehabilitation project may be sponsored by a nonprofit organization, for-profit organization, individual or community housing development organization.

(d) New construction: A new construction project may be sponsored by a nonprofit organization, for-profit organization, housing authority, or Community Housing Development Organization.

(e) Acquisition of vacant land or demolition of improvements: Acquisition of vacant land or demolition of improvements is an eligible activity only when proposed as a portion of a particular project intended to provide affordable housing.

(f) Tenant-based rental assistance: For rental assistance to low income and very low income families.

(g) Operating Support Grant for a certified Community Housing Development Organization: The Department may authorize a grant to support operations during predevelopment development, or construction of a state funded HOME assisted project performed by Community Housing Development Organizations for up to 5 percent of the program's allocation set-aside for such organizations.

(2) Any category of activities described in this rule is subject to restriction by the Department in the availability of program funds in any solicitation or other distribution of program funds.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 456.555, 456.620
Stats. Implemented: ORS 456.559, 456.620
Hist.: HSG 6-1992(Temp), f. & cert. ef. 6-15-92; HSG 10-1992, f. & cert. ef. 11-20-92; HSG 1-1993(Temp), f. & cert. ef. 2-19-93; HSG 3-1993, f. & cert. ef. 8-18-93; HSG 8-1994, f. & cert. ef. 9-9-94; HSG 1-1997, f. & cert. ef. 4-15-97; Renumbered from 813-120-0030, OHCS 1-2008, f. & cert. ef. 1-28-08: Renumbered from 813-120-0105, OHCS 6-2013, f. & cert. ef. 6-21-13; OHCS 11-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-120-0047
Distribution and Expenditure of Funds

(1) The Department may distribute HOME funds pursuant to the Consolidated Plan, OAR chapter 813 and relevant solicitation documents including, but not limited to a NOFA. Distribution may be based on a formula that takes into account the relative housing needs of regions or other factors or funds may be distributed on a statewide basis or by another means of distribution deemed as appropriate by the Department.

(2) The Department may use HOME funds for the demonstration and development of new activities.

(3) The Department will endeavor to make a reservation commitment of HOME funds for a housing project under the state's HOME allocation for a fiscal year within two years after the month in which that allocation is provided by HUD. All HOME funds reserved to a housing project under the state's HOME allocation for a fiscal year must be expended by a recipient within four years after the month in which HUD provides the HOME allocation for that fiscal year.

(4) A recipient of HOME funding for a housing project shall begin expenditure of its HOME funds within six months of the date the funding documents between the recipient and the Department are executed or otherwise as specified therein. The Department may, in its sole discretion, allow one or more extensions upon submission by the recipient of exculpatory documentation acceptable to the Department.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 456.555, 456.620
Stats. Implemented: ORS 456.559, 456.620
Hist.: HSG 6-1992(Temp), f. & cert. ef. 6-15-92; HSG 10-1992, f. & cert. ef. 11-20-92; HSG 1-1993(Temp), f. & cert. ef. 2-19-93; HSG 3-1993, f. & cert. ef. 8-18-93; HSG 8-1994, f. & cert. ef. 9-9-94; HSG 3-1995, f. & cert. ef. 9-25-95; HSG 1-1997, f. & cert. ef. 4-15-97; OHCS 1-2008, f. & cert. ef. 1-28-08: Renumbered from 813-120-0070, OHCS 6-2013, f. & cert. ef. 6-21-13; OHCS 11-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-120-0050
HOME Affordability Requirements

For units in a rental housing project that are funded under the HOME Program:

(1) Initial and continuing contract rents may not exceed the lesser of the fair market rent, determined periodically by HUD for comparable-sized units in the area, or a contract rent that does not exceed 30 percent of adjusted income of a family whose income is 65 percent of the area median income as determined by HUD, adjusted for the number of bedrooms in the unit;

(2) If the project contains five or more HOME-assisted units, a minimum of 20 percent of the HOME-assisted units must be occupied by very-low-income families, each of whom:

(a) Pays no more than 30 percent of their adjusted gross annual income for rent; or

(b) Has contract rents not greater than 30 percent of adjusted gross annual income for a family whose income equals 50 percent of area median income, as determined by HUD so long as the rents described in this paragraph do not exceed the rent limit in paragraph (a) of this subsection;

(3) The HOME-assisted units may be occupied only by low- and very low-income families;

(4) The project may not refuse to lease HOME-assisted units to a family participating in the HUD Section 8 rental certificate or voucher program or HOME tenant-based rental assistance under OAR 813, division 120; and

(5) The HOME assisted units of a project must continuously remain affordable after project completion and such affordability must be subject to enforcement satisfactory to the Department, including by deed restrictions or covenants running with the land for periods not less than the following based on the amount of HOME assistance per unit, regardless of loan or other mortgage terms or ownership transfer, as follows:

(a) For rehabilitation or acquisition, or both, of existing housing per unit amount of HOME funds;

(A) Under $15,000 — 5 years;

(B) $15,000 to $40,000 — 10 years;

(C) More than $40,000 — 15 years.

(b) For acquisition of newly-constructed housing which is acquired within one year of the date of the certificate of initial occupancy, or for new construction, the HOME-assisted units in the project must remain affordable for 20 years.

(c) The Department may require enforceable affordability and habitability terms and obligations in excess of those minimums provided in this section in the exercise of its discretion considering factors that may include, but are not limited to:

(A) Market conditions;

(B) Other funding restrictions;

(C) Solicitation terms and conditions for applicable funding under this Division;

(D) Proposal terms made by or on behalf of the recipient;

(E) The demand for funding under this Division;

(F) The viability of the project;

(G) Other assistance provided to the project; and

(H) Consistency with the Consolidated Plan, successor planning, and applicable federal and state law.

(d) The affordability restrictions may terminate upon foreclosure or other transfer in lieu of foreclosure. The affordability restrictions revive and apply again, however, if at any time following transfer by foreclosure or transfer in lieu of foreclosure, but during the term of the affordability period, either of the following obtains an ownership interest in the project or property:

(A) The owner of record prior to the foreclosure or transfer in lieu of foreclosure; or

(B) Any entity that includes the former owner or those with whom the former owner has or has had family or business ties.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 456.620
Stats. Implemented: ORS 456.559(1)(f)
Hist.: HSG 6-1992(Temp), f. & cert. ef. 6-15-92; HSG 10-1992, f. & cert. ef. 11-20-92; HSG 1-1993(Temp), f. & cert. ef. 2-19-93; HSG 3-1993, f. & cert. ef. 8-18-93; HSG 8-1994, f. & cert. ef. 9-9-94; HSG 3-1995, f. & cert. ef. 9-25-95; HSG 1-1997, f. & cert. ef. 4-15-97; OHCS 1-2008, f. & cert. ef. 1-28-08; OHCS 11-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-120-0060
Program Information

(1) The Department has adopted guidelines for the HOME Program regarding application procedures, Project eligibility, Project selection criteria, forms of financial assistance available, and other applicable information. Program guidelines are published in the Program's application materials.

(2) The guidelines described in OAR 813-120-0060(1) are hereby adopted by reference.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 456.620
Stats. Implemented: ORS 456.559(1)(f)
Hist.: HSG 6-1992(Temp), f. & cert. ef. 6-15-92; HSG 10-1992, f. & cert. ef. 11-20-92; HSG 1-1993(Temp), f. & cert. ef. 2-19-93; HSG 3-1993, f. & cert. ef. 8-18-93; HSG 8-1994, f. & cert. ef. 9-9-94; HSG 3-1995, f. & cert. ef. 9-25-95; HSG 1-1997, f. & cert. ef. 4-15-97; OHCS 1-2008, f. & cert. ef. 1-28-08; Suspended by OHCS 11-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-120-0110
General Administrative and Monitoring Requirements

A recipient of funding for a housing project under HOME Investment Partnerships Program and project owners, if different (collectively, the "recipient"):

(1) Shall submit periodic performance reports and other information as required from time to time by the Department, and at the end of the term of the project affordability period provided in the funding documents required by the Department. The recipient shall submit a summary performance report as prescribed by the Department. A report under this section must include applicable items described in 24 CFR 92.508.

(2) Shall retain financial records, supporting documents and other pertinent records, including but not limited to records related to program activities and HOME assisted projects for the applicable five year period in 24 C.F.R. 92.508 or until after any litigation or audit claim is resolved, whichever is later.

(3) Shall furnish representatives of the Department, HUD, the Comptroller General of the United States, the General Accounting Office and the Oregon Secretary of State access to and permit copying of all books, accounts, documents, records and allow reasonable access to the project and other property pertaining to the receipt of HOME funds, or operation of the project at any such representative's request.

(4) Is subject to and shall fully cooperate with monitoring, reviews and field inspections required by the Department, inter alia, to ensure program compliance.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 456.555, 456.620
Stats. Implemented: ORS 456.559, 456.620
Hist.: HSG 6-1992(Temp), f. & cert. ef. 6-15-92; HSG 10-1992, f. & cert. ef. 11-20-92; HSG 1-1993(Temp), f. & cert. ef. 2-19-93; HSG 3-1993, f. & cert. ef. 8-18-93; HSG 3-1995, f. & cert. ef. 9-25-95; HSG 1-1997, f. & cert. ef. 4-15-97; OHCS 1-2008, f. & cert. ef. 1-28-08; OHCS 11-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-120-0120
Repayment by Recipient of Funding

(1) A recipient of HOME funding from the Department and project owners, if different (collectively, the "recipient") shall repay all such funding to the Department within thirty (30) days of written demand for such repayment by the Department if, inter alia:

(a) The recipient fails to timely complete construction or rehabilitation of the project as required under the funding documents, or otherwise,

(b) The related grant or loan document executed between the Department and recipient with respect to project funding terminates prior to completion by the recipient of project construction or rehabilitation,

(c) The recipient fails to maintain continuously the affordability requirements with respect to the project for the full affordability period set out in the funding documents, or

(d) The Department is required by HUD to repay funding provided by the Department to recipient.

(2) Repayment of HOME funds to the Department pursuant to subsection (1) of this section does not relieve the recipient of its obligation to keep the project continuously affordable for the full affordability period set out in the funding documents with respect to the project or to meet other performance obligations..

(3) Recipient's repayment obligation under this section is in addition to any other obligations owed to the Department and performance by recipient hereunder does not limit or bar any other remedies available to the Department against recipient or with respect to the project.

Stat. Auth.: ORS 456.555, 456.620
Stats. Implemented: ORS 456.559, 456.620
Hist.: HSG 6-1992(Temp), f. & cert. ef. 6-15-92; HSG 10-1992, f. & cert. ef. 11-20-92; HSG 1-1993(Temp), f. & cert. ef. 2-19-93; HSG 3-1993, f. & cert. ef. 8-18-93; OHCS 1-2008, f. & cert. ef. 1-28-08; OHCS 11-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-120-0130
Remedies

(1) If the Department determines that there has been any material failure or default with respect to any term, covenant or condition of the solicitation or funding documents, applicable rules, directives, other program requirements, (including, but not limited to 24 CFR 92), or otherwise, it may exercise any remedy available to it under OAR chapter 813 (including, but not limited to the HOME Manual and General Manual), relevant solicitation or funding documents, program requirements, or applicable law. Remedies include, but are not limited to corrective orders or directives, rescission, termination of funding, recoupment of HOME funds and other Department funding already disbursed with respect to a project – including with applicable interest, recovery for damages, specific performance, injunctive relief, declaratory actions, appointment of a receiver for the project, foreclosure of lien interests, debarment from other Department funding, and other remedies available at law.

(2) A material default has occurred, inter alia, if:

(a) The recipient or project owner has not commenced any significant aspect of the project activities within six months after the award of project funding;

(b) The recipient or project owner has not entered into any necessary third party agreement related to the project within ninety (90) days of the award of project funding;

(c) The recipient or project owner has used HOME funds for activities not approved in these rules, solicitation or funding documents, or other HOME Program requirements;

(d) The recipient or project owner has not completed activities required by these rules, solicitation or funding documents, or other HOME Program requirements in a timely manner;

(e) The recipient or project owner has not complied with any and all affordability, habitability and monitoring compliance obligations required in these rules, solicitation or funding documents, or other HOME Program requirements; or

(f) The recipient or project owner lacks continued capacity to carry out any and all obligations under these rules, solicitation or funding documents, or other HOME Program requirements.

(3) The remedies set forth in this section are cumulative and not exclusive and are in addition to any other rights and remedies provided in this Division, other Department rules, the solicitation or funding documents, or otherwise available at law or otherwise. The Department may exercise any or all remedies available to it, and in such manner as it, in its sole discretion, determines appropriate.

(4) A recipient or project owner shall take all action necessary to enforce all terms of any agreement with a third party in furtherance of its obligations to the Department where such third party materially fails to comply with the terms of such agreement and shall act to recover on behalf of the Department any costs, expenses and damages that may arise as a result of the breach of the agreement. The recipient, by its execution of its funding documents with the Department regardless of whether the agreement expressly so states, acknowledges and agrees that the Department at its sole discretion may:

(a) Enforce the terms of any agreement the recipient has with a third party regarding the program or project; or

(b) Recover any sums that become due as the result of a breach of the agreement.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 456.555, 456.620

Stats. Implemented: ORS 456.559, 456.620

Hist.: HSG 6-1992(Temp), f. & cert. ef. 6-15-92; HSG 10-1992, f. & cert. ef. 11-20-92; HSG 1-1993(Temp), f. & cert. ef. 2-19-93; HSG 3-1993, f. & cert. ef. 8-18-93; HSG 1-1997, f. & cert. ef. 4-15-97; OHCS 1-2008, f. & cert. ef. 1-28-08; OHCS 11-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-120-0140

Request for Reconsideration; Waiver

(1) An Applicant may, in writing, request the Director reconsider the Department's funding decision. The Applicant's request shall be filed with the office of the Director within 30 days of the Department's funding decision and shall state with particularity the basis for reconsideration. The Director may require additional information from the Applicant and shall consider a request which complies with the requirements of this OAR 813-120-0140. The Director's decision regarding such request is final.

(2) The Director may waive or modify any non-statutory requirements of HOME unless such waiver or modification would violate any applicable federal or state statutes or regulations.

Stat. Auth.: ORS 456.620

Stats. Implemented: ORS 456.559(1)(f)

Hist.: HSG 6-1992(Temp), f. & cert. ef. 6-15-92; HSG 10-1992, f. & cert. ef. 11-20-92; HSG 1-1993(Temp), f. & cert. ef. 2-19-93; HSG 3-1993, f. & cert. ef. 8-18-93; OHCS 1-2008, f. & cert. ef. 1-28-08; Suspended by OHCS 11-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-120-0142

Transfer of Recipient, Assistance or Ownership; Subordinate Liens; Encumbrances

(1) A recipient of assistance under the HOME program or owner of a project for which such assistance is provided may not transfer or allow any transfer of any interest in itself, the assistance or the project, allow a subordinate lien or otherwise encumber the project, or any portion or interest therein, unless the Department first approves the transfer, subordinate lien or encumbrance in writing. Any such transfer is subject to the payment to the Department of a transfer charge as established by the Department. If the recipient or project owner effects or allows a transfer, subordinate lien or encumbrance without prior written approval by the Department, the transfer, subordinate lien or encumbrance is voidable and remains subject to the approval or disapproval of the Department and the recipient or owner responsible effecting or for allowing the transfer, subordinate lien or encumbrance and any transferees, jointly and severally, are subject to a charge by the Department with respect to its review and treatment of any such event.

(2) The Department may condition its approval upon such terms and conditions as it, in its sole discretion, may require. Factors the Department may consider in determining whether or not to give approval to a transfer, subordinate lien or encumbrance include, but are not limited to:

(a) The financial investment of the Department in the project;

(b) Preservation of existing housing;

(c) The transferee's ability to maintain and manage the project for the needs of the residents, the integrity of the housing and as security for the assistance;

(d) The effect of the transfer, subordinate lien or encumbrance upon the financial integrity of the project, repayment of the assistance, use of the project for its intended purposes, and continuity of the program; and

(e) Continued compliance with applicable state and federal laws, rules and regulations.

Stat. Auth.: ORS 456.555

Stats. Implemented: ORS 456.555, 456.559, 456.625

Hist.: OHCS 11-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

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Rule Caption: Establishes the process for public contracts and procurements

Adm. Order No.: OHCS 12-2013(Temp)

Filed with Sec. of State: 6-21-2013

Certified to be Effective: 6-21-13 thru 12-18-13

Notice Publication Date:

Rules Adopted: 813-006-0040

Rules Amended: 813-006-0005, 813-006-0010, 813-006-0015, 813-006-0020, 813-006-0025, 813-006-0030, 813-006-0035

Subject: The rules establish the procedures for public contracts and procurements by the Department as well as its other contracting and procurement activities. The Department has completed a significant reorganization as to how it solicits and administers funding awards for Department programs as part of the restructure. These rule changes are designed to reflect the significant reorganization of the Department.

Rules Coordinator: Sandy McDonnell—(503) 986-2012

813-006-0005

Purpose

OAR chapter 813, division 006 is promulgated to establish the procedures for public contracts and procurements by the Department as well as its other contracting and procurement activities. The Department is exempt from all provisions of the Oregon Public Contracting Code as contained in ORS chapters 279A, 279B and 279C, except with respect to certain aspects relating to the procurement of goods and services under ORS chapter 279B. And, the Department has all authority to procure or supervise the procurement, inter alia, of goods, services and personal services for which it is subject to ORS chapter 279B. Also, most contracting by the Department is not covered by the Oregon Public Contracting Code even if it were applicable to the Department. Accordingly, the Department has chosen to fashion its own standards, considerations and procedures with respect to its procurement and contracting activities.

Stat. Auth.: ORS 90.800 – 90.840, 91.886, 317.097, 279A.025, 279A.065, ORS 456.515–456.725 & 458.210 – 458.650

Stats. Implemented: ORS 90.800 – 90.840, 92.886, 279B, 317.097, 456.515 - 456.725, 307.651 & 458.005 –458.740

Hist.: HSG 14-1987, f. & ef. 12-21-87; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 8-1991, f. & cert. ef. 12-23-91; OHCS 12-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-006-0010

Basic Policy and Approach

(1) The model rules of the Attorney General adopted pursuant to ORS 279A.065 do not apply to the Department. The Department will, however, consider the Attorney General's model rules for guidance in exercising its contracting and procurement discretion, particularly with respect to procurements of goods and services under ORS chapter 279B. Other factors that the Department may consider include, but are not limited to:

(a) The subject matter of the proposed contract and appropriate means to ensure successful performance at competitive costs where practical;

(b) Specificity with respect to communication and reservation of rights in any procurement;

(c) Clarity in the naming and description of parties as well as consideration of appropriate preferences;

(c) Ascertaining and obtaining appropriate representations and warranties as to the qualifications of parties;

(d) Specificity with respect to consideration and applicable time periods;

(e) Specificity with respect to terms and covenants, particularly as to standards applicable to the performance of all work or delivery of goods;

(f) Identification of remedies and their suitability to protect Department and program interests;

(g) Identification of insurance and other risk mitigation terms and the appropriate balance of such measures with potential risks and costs;

(h) Requirements for compliance with applicable laws, including those applicable to funding sources and nondiscrimination;

(i) Use of appropriate terms with respect to standard provisions such as governing law, venue, waiver, exhibits, merger, etc.

(2) Contracting and procurement procedures, requirements and standards with respect to program loans and similar extensions or advances of funds or other funding awards are set forth in the divisions of OAR chapter 813 that specifically address those programs. Relevant general procedures, requirements and standards are set forth in Divisions 001 – 005, particularly Division 005.

(3) Contracting and procurement procedures related to the investment of Department funds and other financial transactions that cannot practically be established, including with resort to the competitive contractor selection procedures of ORS 279B.050 to 279B.085, will be accomplished in consultation with financial advisors, legal counsel and other appropriate professionals. As a general standard, the Department will seek to employ procedures as are practical to introduce competitive efficiencies and sound selections given the particular circumstances, complex regulations and governing law applicable to such financial and investment transactions.

(4) In contracting for consultant or other personal services, as well as goods or other services, the Department will consider factors including those described above in subsection (1) and employ the following procedures as applicable, except when the Director determines that an emergency or other good cause exists to excuse the Department from one or more of those procedures, such as when the personal services contract involves data processing services. The Department will comply with Executive Department OAR 122-031-0005 or 122-036-0005 for data processing personal services contracts.

(5) The Department will contract for consultant and other personal services: (i) when the specialized skills, knowledge, and resources are not available within the Department; (ii) when the work cannot be done in a reasonable time within the Department's own work force; (iii) when an independent and impartial evaluation of a situation is required by a consultant or other provider with recognized professional expertise and stature in a field; (iv) when it will be less expensive to contract for the work; (v) when the Department is directed by statute or otherwise to contract for services; or (vi) when the Department otherwise determines that contracting for a consultant or other personal services will best serve the purpose of fulfilling its statutory or other duties. The Department may contract for other goods and services necessary or appropriate for the operation of the Department. Contracts will be awarded only after the approval of the Director or his/her designee, subject to minimum limit exceptions.

(6) Agreements for the services of a contractor who is a member of the Public Employees' Retirement System and who is employed in another public department usually will be by interagency agreement. Exceptions may be granted by the Director or his/her designee when such an agreement is impractical and when the work will be done on the contractor's own time. Such exceptions normally will be processed as a personal services contract.

(7) The Department will seek to ensure competition and include performance standards to the maximum extent practicable when awarding personal services contracts as well as financial assistance agreements designed, inter alia, to obtain services in furtherance of a Department-supervised program.

(5) In selecting between two or more equally qualified bidders, preference will be given to individuals residing in Oregon and businesses that have an office in Oregon.

Stat. Auth.: ORS 90.800 – 90.840, 91.886, 317.097, 279A.025, 279A.065, ORS 456.515–456.725 & 458.210 – 458.650

Stats. Implemented: ORS 90.800 – 90.840, 92.886, 279B, 317.097, 456.515 - 456.725, 307.651 & 458.005 –458.740

Hist.: HSG 14-1987, f. & ef. 12-21-87; HSG 3-1989(Temp), f. & cert. ef. 6-8-89; HSG 6-1989, f. & cert. ef. 11-3-89; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 8-1991, f. & cert. ef. 12-23-91; OHCS 12-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-006-0015
Definitions

(1) Terms used in OAR chapter 813, division 6 have meanings as defined in the Act, in 813-005-0005 and herein.

(2) As used in these rules, unless otherwise indicated by the context:

(a) "Consultant" means an individual or firm that has been found qualified to do specified types of work for the agency and with whom the Department may contract;

(b) "Competitive Procurement" is a formal procurement method whereby proposals or applicants are requested from a number of sources and the Request for Proposals or other solicitation document is widely published or otherwise distributed;

(c) "Noncompetitive Procurement" is procurement through solicitation of a proposal from only one source or on a first- come first-served basis;

(d) "Small Purchase Procurement Procedures" are those relatively simple and informal procurement methods whereby price or rate quotations are obtained from a number of sources and selection made on the basis of costs and other applicable criteria.

Stat. Auth.: ORS 90.800 – 90.840, 91.886, 317.097, 279A.025, 279A.065, ORS 456.515–456.725 & 458.210 – 458.650

Stats. Implemented: ORS 90.800 – 90.840, 92.886, 279B, 317.097, 456.515 - 456.725, 307.651 & 458.005 –458.740

Hist.: HSG 14-1987, f. & ef. 12-21-87; HSG 3-1989(Temp), f. & cert. ef. 6-8-89; HSG 6-1989, f. & cert. ef. 11-3-89; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 8-1991, f. & cert. ef. 12-23-91; OHCS 12-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-006-0020
Procurement Method

(1) The department will comply with the requirements of ORS 200.035.

(2) The department may allow for preference of or limit competition for a public contract for goods and services or for any other public contract estimated to cost $50,000 or less, to contracting entities owned or controlled by persons described in subsection (1) of ORS279A.100.

(3) The department may participate in, sponsor, conduct, or administer cooperative procurements pursuant to ORS 279A.200 through 279A.225.

(4) Small Purchase Procurement Procedures as outlined in OAR 813-006-0030 may be used for the procurement of goods and services estimated to cost not more than $5,000 per agreement per fiscal year. Price or rate quotations will be sought from at least three qualified sources, if practical. This procedure does not govern program solicitations.

(5) Competitive Procurement procedures as outlined in OAR 813-006-0025 will be used for goods and services, as well as personal service contracts, estimated to cost in excess of $5,000 per agreement per fiscal year. Competitive Procurement may be used for contracts of less than $5,000 whenever the Department determines that it would be prudent and advantageous to do so. Exceptions may be granted to accommodate one or more of the conditions described in section (3) of this rule with the approval of the Director.

(6) Noncompetitive Procurement procedures may be used for goods and services, as well as personal services contracts if:

(a) The item or service is available only from a single source, or the sole source has special skills or special characteristics that are reasonably only available from that source or based upon the particular provider's expertise, experience or situation;

(b) Public need or emergency weighs against the delay incurred by competitive solicitation;

(c) After solicitation of a number of sources, competition is determined inadequate; or

(d) The contract is a renewal of an existing contract, subject to approval by all required parties.

Stat. Auth.: ORS 90.800 – 90.840, 91.886, 317.097, 279A.025, 279A.065, ORS 456.515–456.725 & 458.210 – 458.650

Stats. Implemented: ORS 90.800 – 90.840, 92.886, 279B, 317.097, 456.515 - 456.725, 307.651 & 458.005 –458.740

Hist.: HSG 14-1987, f. & ef. 12-21-87; HSG 3-1989(Temp), f. & cert. ef. 6-8-89; HSG 6-1989, f. & cert. ef. 11-3-89; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 8-1991, f. & cert. ef. 12-23-91; OHCS 12-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-006-0025
Competitive Procurement Procedures

(1) A Request for Proposals (RFP) or similar solicitation (collectively, RFP) will be prepared for the contracts for which Competitive Procurement procedures will be used. The RFP will normally include, at a minimum, the following information:

(a) Date and hour by which proposals or other responses must be received;

(b) Return address where proposals or other responses must be received;

(c) Description of work;

(d) Evaluation criteria; and

(e) Department project manager's name, address and phone number.

(2) The Department will notify persons who have indicated a desire to be notified of contracting opportunities or that have indicated expertise in the subject area, and any other persons deemed necessary, of projects for

which an RFP may be issued. Notification of the project for which an RFP may be issued may be announced to the public and may be advertised in appropriate periodicals. The RFP will be sent to all persons responding to the notification in the required manner.

(3) Exceptions to section (2) of this rule may be granted by the Director or his/her designee when the RFP is preceded by a Request for Information (RFI). When an RFI is widely distributed to solicit information and interest in a proposed contract, eligibility for the subsequent RFP may be limited to parties responding to the RFI.

(4) Proposals will be evaluated in accordance with the evaluation criteria included in the RFP. An objective rating system will be used in the evaluation process. Records pertaining to the procurement process and selection of the consultant shall be maintained in the Department's files.

(5) Exceptions to the notification procedures in sections (2) and (3) of this rule may be granted by the Director or his/her designee if warranted by time, cost, or other relevant considerations.

Stat. Auth.: ORS 90.800 – 90.840, 91.886, 317.097, 279A.025, 279A.065, ORS 456.515–456.725 & 458.210 – 458.650
Stats. Implemented: ORS 90.800 – 90.840, 92.886, 279B, 317.097, 456.515 - 456.725, 307.651 & 458.005 –458.740
Hist.: HSG 14-1987, f. & ef. 12-21-87; HSG 3-1989(Temp), f. & cert. ef. 6-8-89; HSG 6-1989, f. & cert. ef. 11-3-89; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 8-1991, f. & cert. ef. 12-23-91; OHCS 3-2012(Temp), f. & cert. ef. 4-2-12 thru 9-28-12; Administrative correction 10-29-12; OHCS 12-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-006-0030
Small Purchase Procurement Procedures

(1) A Statement of Work and request for price or rate quotation shall be developed and submitted to prospective contractors with which the Department has had previous successful experience or which are believed by the Department to be qualified to offer the needed services. The Statement of Work and request for quotation may be communicated orally or in writing.

(2) At least three price quotations shall be obtained from qualified sources unless there are fewer than three qualified sources interested in the contract.

(3) Contractor selection shall be made on the basis of the cost estimate and other pertinent information such as qualifications, experience, reference check and project approach.

Stat. Auth.: ORS 90.800 – 90.840, 91.886, 317.097, 279A.025, 279A.065, ORS 456.515–456.725 & 458.210 – 458.650
Stats. Implemented: ORS 90.800 – 90.840, 92.886, 279B, 317.097, 456.515 - 456.725, 307.651 & 458.005 –458.740
Hist.: HSG 14-1987, f. & ef. 12-21-87; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 8-1991, f. & cert. ef. 12-23-91; OHCS 12-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-006-0035
Contracting Procedure and Responsibility

The procedures for screening and selection of providers of goods or services, as well as personal service contractors, relating the responsible parties to their actions, are as follows:

(1) Contractor — Action: Submit qualifications, credentials, costs estimates, project approach and other pertinent information relating to the project announcement.

(2) Department project manager — Action:

(a) Determines that work on a project requires the services of a consultant;

(b) Prepares cost estimate for contract;

(c) Determines type of selection and screening process to be used to select a contractor and obtains approval of Director or his/her designee to begin contracting process for consultant services;

(d) Notifies prospective contractors of projects for which Competitive Procurement or Small Purchase Procurement Procedures will be used as required by OAR 813-006-0025 or 813-006-0030;

(e) Completes screening and selection procedure and selects a contractor according to Department rules;

(f) Forwards draft of contract to the Department's contract officer for approval;

(g) Forwards draft of contract that totals $100,000 or more to Attorney General for review and approval of legal sufficiency, unless contract form is subject to a group exception and has previously been approved by Attorney General. The project manager will forward contract drafts for lesser amounts to the Attorney General for review where particular issues merit such review or there is an expectation that the contract amount may subsequently be amended to an aggregate amount at or over $100,000; and

(h) When notified by the contract officer, authorize contractor to begin work.

(3) Director or his/her designee — Action:

(a) Approves each project's scope and budget and use of the contracting process;

(b) Makes direct and emergency appointments and grants exceptions as necessary and in accordance with Department rules;

(c) Approves/disapproves goods, services, and personal services contracts and all subsequent amendments; and

(d) Signs approved contracts.

(4) Department contract officer — Action:

(a) Reviews contract and selection process for compliance with Department rules and other applicable state and federal rules and regulations;

(b) Maintains a file on the selection and screening of applicants for consultant services.

(c) Obtains contractor's signature on approved contract;

(d) Forwards one copy of final approved contract to contractor and retains a copy of the contract with original signatures for the Department's contract file;

(e) Notifies project manager when contractor may begin work.

Stat. Auth.: ORS 90.800 – 90.840, 91.886, 317.097, 279A.025, 279A.065, ORS 456.515–456.725 & 458.210 – 458.650
Stats. Implemented: ORS 90.800 – 90.840, 92.886, 279B, 317.097, 456.515 - 456.725, 307.651 & 458.005 –458.740
Hist.: HSG 14-1987, f. & ef. 12-21-87; HSG 3-1989(Temp), f. & cert. ef. 6-8-89; HSG 6-1989, f. & cert. ef. 11-3-89; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 8-1991, f. & cert. ef. 12-23-91; OHCS 12-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-006-0040
Discretionary Action

(1) As it deems necessary or appropriate for its purposes, the Department may waive or deviate from the foregoing provisions of this Division to the extent the Department's statutory authority to employ its own procurement and contracting procedures allow. Factors that the Ddepartment may consider in waiving or deviating from such provision or in determining what other procurement or contracting procedures it will apply in a particular circumstance may include, but are not limited to:

(a) Serving program or other Department purposes;

(b) Collaborating with reputable and effective partners;

(c) Leveraging past resources, experience, or services;

(d) Efficiently and effectively using department resources;

(e) Addressing exigent or unusual circumstances;

(f) Advancing the department or maintenance of safe, sanitary, and affordable housing;

(g) Advancing the delivery and effectiveness or community services;

(h) Building or sustaining the capacity of department partners;

(i) Promoting the coordination of relevant skills, resources, and efforts;

(j) Educating persons and entities concerning housing and community services needs and opportunities; and

(k) Ensuring compliance with department or other applicable standards.

(2) Included within this authority to waive or deviate from such procedures, or to apply other procurement or contracting procedures in particular circumstances, the Department may amend an existing contract without additional competition, inter alia, to extend its term, to modify the compensation, to delete services, or to add any services or goods within the scope of the relevant procurement provided the amendment, in the Department's determination, is consistent with relevant factors identified in the subsection or consistent with factors otherwise relevant to such action.

Stat. Auth.: ORS 90.800 – 90.840, 91.886, 317.097, 279A.025, 279A.065, ORS 456.515–456.725 & 458.210 – 458.650
Stats. Implemented: ORS 90.800 – 90.840, 92.886, 279B, 317.097, 456.515 - 456.725, 307.651 & 458.005 –458.740
Hist.: OHCS 12-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

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Rule Caption: Amends the process for soliciting and administering funding awards for the General Housing Account.
Adm. Order No.: OHCS 13-2013(Temp)
Filed with Sec. of State: 6-21-2013
Certified to be Effective: 6-21-13 thru 12-18-13
Notice Publication Date:
Rules Adopted: 813-055-0065, 813-055-0095
Rules Amended: 813-055-0001, 813-055-0010, 813-055-0020, 813-055-0040, 813-055-0050, 813-055-0075, 813-055-0085, 813-055-0105, 813-055-0115
Rules Suspended: 813-055-0060, 813-055-0100, 813-055-0110
Subject: The General Housing Account carries out the allocation of monies deposited in the General Housing Account by meeting the

critical housing needs, building the organizational capacity of affordable housing partners throughout the state, and requiring equitable distribution of resources over time based on objective measures of need. The department has completed a significant reorganization as to how it solicits and administers funding awards for this program as part of the restructure. These rule changes are designed to reflect the significant reorganization of the department.

Rules Coordinator: Sandy McDonnell—(503) 986-2012

813-055-0001
Purpose

OAR chapter 813, Division 55, is promulgated to carry out the allocation of monies deposited in the General Housing Account and to carry out the account's purpose of meeting critical housing needs, building the organizational capacity of affordable housing partners throughout the state, and requiring equitable distribution of resources over time based on objective measures of need. Additional policies and instructions are outlined in the General Housing Account Program (GHAP) Manual dated June 21, 2013 (the "GHAP Manual" or "Manual"), incorporated herein by reference. The Manual may be accessed online at the Department's website.

Stat. Auth.: ORS 456.555, 458.665
Stats. Implemented: ORS 456.515 - 456.725, 458.665
Hist.: OHCS 5-2009, f. & cert. ef. 12-22-09; OHCS 13-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-055-0010
Definitions

Certain terms used in this Division are defined in the Act, OAR 813-005-0005, and herein. Other terms may be identified in the text of this division (including by incorporation), otherwise in chapter 813, or applicable law. As used in this division:

(1) "Low income household" means a household that receives more than 50 percent and not more than 80 percent of the median family income for the area, subject to adjustments for family size and for areas with unusually high or low incomes or housing costs, all as determined according to information from the U.S. Department of Housing and Urban Development.

(2) "Very low income household" means a household that receives 50 percent or less of the median family income for the area, subject to adjustments for family size and for areas with unusually high or low incomes or housing costs, all as determined according to information from the U.S. Department of Housing and Urban Development.

Stat. Auth.: ORS 456.555, 458.665
Stats. Implemented: ORS 456.515 - 456.725, 458.665
Hist.: OHCS 5-2009, f. & cert. ef. 12-22-09; OHCS 13-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-055-0020
Distribution of GHAP Funds; Eligibility

(1) The Department may distribute GHAP program funds consistent with OAR chapter 813 pursuant to relevant solicitation documents including, but not limited to a Notice of Funding Availability ("NOFA") or as otherwise determined by the Department. Funding may take the form of a grant, loan or otherwise as the Department determines necessary or appropriate, for either or both of the following purposes:

(a) For financing assistance with respect to the construction, acquisition, rehabilitation or operation of affordable multifamily rental housing developments for low income households or very low income households.

(b) For expanding or building affordable housing development capacity, by enhancing the capacity of non-profit entities and housing authorities to develop affordable housing.

(2) Subject to the limitations of any specific solicitation or distribution, any of the following persons or entities may apply for GHAP assistance with respect to the financing of affordable multifamily rental housing developments:

(a) A nonprofit corporation established under ORS chapter 65;

(b) A housing authority established under ORS 456.055 to 456.235;

(c) A local government as defined in ORS 197.015;

(d) A manufactured dwelling park cooperative as established under ORS 62.800 to 62.815;

(e) A for-profit entity;

(f) A Native-American tribe; or

(g) An individual.

(3) Subject to the limitations of any specific solicitation or distribution, any person or entity including, but not limited to those identified in subsection (2) is eligible to apply for GHAP assistance to enhance the capacity of non-profit entities and housing authorities to develop affordable housing.

Stat. Auth.: ORS 456.555, 458.665
Stats. Implemented: ORS 456.515 - 456.725, 458.665
Hist.: OHCS 5-2009, f. & cert. ef. 12-22-09; OHCS 13-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-055-0040
Application Procedure and Requirements

(1) The process to obtain GHAP assistance typically will be spelled out in the solicitation documents issued by the Department. In addition to, or in lieu of formal solicitation documents, the Department may provide other means for accessing GHAP assistance. Additional direction and guidance may be found in the GHAP Manual and General Manual.

(2) The Department may require payment of a non-refundable application charge from any applicant requesting GHAP funds through a formal solicitation or otherwise.

(3) The Department may require payment of other charges with respect to its reasonably anticipated costs in processing applications, coordinating programs or with other project participants, providing funding, negotiating documents, monitoring compliance, evaluating and documenting transfers, or otherwise. The Department may require payment of a supplemental application charge from applicants requesting additional resources for projects that have already been funded by the Department.

(4) The Department may refuse to process applications or terminate processing if it determines an application to be incomplete or that it fails to satisfy threshold standards for further processing.

(5) An applicant shall submit to the Department, on the application form and in accordance with the application process prescribed by the Department, such information as the Department may require, including but not limited to:

(a) The name, address and telephone number of applicant;

(b) The type of assistance requested;

(c) A written description of the project, including the number of units, unit mix, proposed rents, site location, amenities, and any other information requested by the Department.

(d) A statement of project purpose indicating the housing type and residents to be housed, and the length of the affordability period;

(e) A pro forma of project income and expenses;

(f) The amount of funding requested and total project development costs, including a description and documentation of all project funding sources and uses;

(g) A narrative of the applicant's experience in developing affordable housing, including the experience of all members of the project development team;

(h) A narrative of the experience of the applicant's management team or agent as it relates to operating affordable housing projects;

(i) A description of resident services, if any, to be provided;

(j) A narrative of the applicant's experience in providing resident services, including the experience of any relevant project team members;

(k) A description of the applicant's readiness to proceed with project activities;

(l) A schedule for completion of project activities;

(m) The need of a nonprofit or housing authority to build its capacity to develop and operate housing serving low income and very low income populations; and

(n) How the nonprofit or housing authority would employ GHAP assistance to build its capacity to develop and operate housing serving low income and very low income populations.

(6) The Department may restrict the amount and/or type of assistance available in any solicitation or other provision of assistance and restrict the type or number of applicants or recipients eligible for assistance in a particular funding process.

Stat. Auth.: ORS 456.555, 458.665
Stats. Implemented: ORS 456.515 - 456.725, 458.665
Hist.: OHCS 5-2009, f. & cert. ef. 12-22-09; OHCS 13-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-055-0050
Application Review

(1) An application for assistance from the GHAP program is subject to the Department's evaluation and approval, disapproval or modification according to criteria in the solicitation documents or otherwise that may include, but are not limited to the following:

(a) The amount of available funds in the GHAP program;

(b) The availability of other sources of assistance;

(c) The applicant's efforts to leverage other public or private funds;

(d) Whether the project is financially feasible and the financial strength and history of the prospective recipient;

(e) The location of the project site, including its proximity to transportation, shopping, social, commercial and recreational facilities, medical services and such other facilities and services that best serve the residents;

(f) Availability of street, sewer, water, utilities and other public services;

(g) Architectural design, including aesthetic quality, soundness of construction, energy efficiency, and suitability to the needs of the residents to be served;

(h) Whether or not the project will include fee ownership of the real property;

(i) Compliance with the Consolidated Plan, applicable local comprehensive plan, land use regulations, housing codes and other applicable standards;

(j) Market demand;

(k) The target population to be served;

(l) The experience of the developer, contractors, architects, consultants and management agent in developing, constructing and operating housing projects;

(m) The Department's experience with and the reputation, experience, capacity and legal history and status of the applicant and its agents, representatives, employees and contractors;

(n) Whether the project in comparison to others best achieves the purposes of the GHAP program;

(o) The need of a nonprofit or housing authority to build its capacity to develop and operate housing serving low income and very low income populations;

(p) How the nonprofit or housing authority proposes to use GHAP funds to build its capacity to develop and operate housing serving low income and very low income populations;

(q) Other factors that the Department determines to be relevant including, but not limited to any evaluation criteria in the solicitation documents, GHAP Manual, General Manual, or otherwise.

(2) If the Department approves an application in whole or in part and if the amount of the GHAP assistance or any other Department funding approved by the Department that was considered by the Department in setting the amount of GHAP assistance to be provided ("Complementary Funding") meets or exceeds the threshold amount established in OAR 813-001-0007(1) for review by the State Housing Council, the approval of GHAP assistance by the Department is subject to review and approval by the Council of such GHAP funding and any such Complementary Funding. The Council may approve, deny, modify or further condition funding subject to its review. Based upon any relevant Council determination, including with respect to Complementary Funding, approval of GHAP funding may be deemed revoked, or be modified and further conditioned.

Stat. Auth.: ORS 456.555, 458.665
Stats. Implemented: ORS 456.515 - 456.725, 458.665
Hist.: OHCS 5-2009, f. & cert. ef. 12-22-09; OHCS 13-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-055-0060
Application Review

(1) The Department shall consider all applications and make application approval, deny application approval, forward for State Housing Council review, or request additional information within the timeframe set forth in the application materials.

(2) A grant, loan or other funding award in excess of an applicable threshold, as established by the State Housing Council, requires Council review and approval under ORS 456.561. The Council shall approve or disapprove the application at a public hearing of the Council, pursuant to ORS 456.571(2).

(3) In reviewing applications for assistance, the Department and the Council, as appropriate, may consider, in addition to any special evaluation criteria, the following:

(a) Amount of available funds in the Program;

(b) Ability of the applicant to meet proposed terms of loan repayment in cases where funding is awarded as a loan;

(c) Availability of other sources of assistance; and

(d) Applicant's efforts to leverage public or private funds.

(4) The Department shall select those applications which, in the judgment of the Department, best achieve the purposes of the Program and any evaluation criteria outlined in the Program application forms and handbooks.

Stat. Auth.: ORS 456.515 - 456.725 & 458.600 - 458.660
Stats. Implemented: ORS 458.660
Hist.: OHCS 5-2009, f. & cert. ef. 12-22-09; Suspended by OHCS 13-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-055-0065
Form of Assistance; Documentation

(1) The Department may provide GHAP funds in the form of a grant or a loan, or a combination of both. Loan rates and terms, if applicable shall be determined by the Department based on a project's or applicant's needs and cash flow, other funding resources, market conditions and an applicant's capacity to repay GHAP funds. Preference may be given to those applicants requesting loans that show sufficient project cash flow to repay the loan. The Department normally will notify an applicant in a written reservation letter as to the amount and form of GHAP assistance, if any, to be provided, together with notable conditions. Such reservation commitments remain subject to Department rules, solicitation requirements, applicable law, and the negotiation, execution and recording (if required) of documents satisfactory to the Department.

(2) Each recipient of project development assistance shall, inter alia, execute funding agreements satisfactory to the Department including, but not limited to a project use agreement, containing such terms regarding fees, interest rates, repayment terms, performance criteria, reporting requirements, restrictive covenants, and other terms as the Department considers appropriate or necessary for the type and use of assistance provided. Each relevant funding agreement, including the use agreement, must be:

(a) (If the recipient owns the project property at the time of disbursement) recorded as an encumbrance on the project property before any GHAP funds are advanced; or

(b) (If the recipient does not own the project property at the time of disbursement) at the discretion of the Department, placed in an escrow account established by the recipient satisfactory to the Department and subject to such further conditions as the Department may require, including the recording of restrictive covenants running with the project property for the applicable affordability period, with appropriate lien priority and taking effect upon close of escrow.

(3) The Department may require a recipient to execute and record such funding documents satisfactory to the Department as it considers appropriate in its sole discretion.

Stat. Auth.: ORS 456.555, 458.665
Stats. Implemented: ORS 456.559, 456.620, 456.625, 458.650, 458.665
Hist.: OHCS 13-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-055-0075
Distribution and Expenditure of Funds

(1) The Department may distribute GHAP funds pursuant to relevant solicitation documents including, but not limited to a NOFA, or otherwise under this Division, and pursuant to relevant funding documents.

(2) Distribution of GHAP funds, whether for multifamily affordable housing development or affordable housing capacity building is subject to a general formula developed by the Department that provides for an equitable distribution of resources statewide over time based on objective measures of need, including, but not limited to:

(a) The number and percentage of low and very low-income households in an area;

(b) The estimated need for affordable housing as determined by the Department and the State Housing Council; and

(c) The need of a nonprofit or housing authority to build its capacity to develop and operate housing serving low- and very- low-income populations.

Stat. Auth.: ORS 456.555, 458.665
Stats. Implemented: ORS 456.559, 456.620, 456.625, 458.650, 458.665
Hist.: OHCS 5-2009, f. & cert. ef. 12-22-09; Renumbered from 813-055-0030, OHCS 7-2013, f. & cert. ef. 6-21-13; OHCS 13-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-055-0085
Charges

(1) An applicant requesting General Housing Account funds shall pay an application fee or charge as may be required by the Department.

(2) An applicant or owner of a multifamily affordable housing development project that receives GHAP assistance shall pay a monitoring fee or charge as may be required by the Department.

(3) The applicant or owner of a project that receives GHAP assistance shall pay such other charges with respect to the Department's anticipated costs and expenses of administration as the Department may require.

Stat. Auth.: ORS 456.555, 458.665
Stats. Implemented: ORS 456.515 to 456.725, 458.665
Hist.: OHCS 5-2009, f. & cert. ef. 12-22-09; Renumbered from 813-055-0070, OHCS 7-2013, f. & cert. ef. 6-21-13; OHCS 13-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-055-0095
Transfer of Recipient, Assistance or Ownership; Subordinate Liens; Encumbrances

(1) A recipient of GHAP assistance or owner of a project for which such assistance is provided may not transfer or allow any transfer of any interest in itself, the assistance or the project, allow a subordinate lien or otherwise encumber the project, or any portion or interest therein, unless the Department first approves the transfer, subordinate lien or encumbrance in writing. Any such transfer is subject to a payment to the Department of a fee or charge as may be required by the Department. If the recipient effects or allows a transfer, subordinate lien or encumbrance without prior written approval by the Department, the transfer, subordinate lien or encumbrance is voidable and remains subject to the approval or disapproval of the Department and the recipient or owner responsible for allowing the transfer, subordinate lien or encumbrance and any transferees, jointly and severally, are subject to a charge by the Department with respect to its review and treatment of any such event.

(2) The Department may condition its approval upon such terms and conditions as it, in its sole discretion, may require. Factors the Department may consider in determining whether or not to give approval to a transfer, subordinate lien or encumbrance include, but are not limited to:

(a) The financial investment of the Department in the project or recipient;

(b) Preservation of existing housing;

(c) Preservation of affordable housing development capacity;

(d) The transferee's ability to maintain and manage the project for the needs of the residents, the integrity of the housing and as security for the assistance;

(e) The effect of the transfer, subordinate lien or encumbrance upon the financial integrity of the project, repayment of the assistance, use of the project for its intended purposes, and continuity of the program; and

(f) Continued compliance with applicable state and federal laws, rules and regulations.

Stat. Auth.: ORS 456.555, 458.665
Stats. Implemented: ORS 456.515 - 456.725, 458.665
Hist.: OHCS 13-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-055-0100
Sanctions

(1) The Department may invoke sanctions against a recipient that fails to comply with the provisions of its grant or loan agreements. The following circumstances may warrant sanctions:

(a) General Housing Account funds have not been disbursed within one year of award by the Department or the recipient;

(b) Any local or private party funding agreements related to the project are not executed within six months of the award of General Housing Account funds;

(c) There is a material breach of the Use Agreement;

(d) The Use Agreement was not recorded on the property required by OAR 813-042-0050(3) or as agreed; or

(e) The Department finds that significant corrective actions are necessary to protect the integrity of the project funds, and those corrective actions are not, or will not be, made within a reasonable time (the funds were used for costs not eligible under the General Housing Account program or the project has not served the population stated in the Use Agreement).

(2) One or more of the following sanctions may be imposed by the Department:

(a) Prohibit a recipient from applying for future General Housing Account assistance or other Department assistance;

(b) Revoke an existing General Housing Account award;

(c) Withhold unexpended General Housing Account funds;

(d) Require return of General Housing Account funds that have been disbursed to the recipient but not expended by the recipient;

(e) Require repayment of expended General Housing Account funds; and

(f) Invoke other remedies that may be incorporated into the Use Agreement.

(3) Sanctions will not be imposed by the Department until the recipient has been notified in writing of its deficiencies and given a reasonable time to respond and correct the deficiencies noted. The sanctions and remedies set forth in this OAR 813-042-0100 are cumulative and not exclusive and are in addition to any other rights and remedies provided by law or under the Use Agreement.

Stat. Auth.: ORS 456.515 - 456.725 & 458.600 - 458.660
Stats. Implemented: ORS 458.660
Hist.: OHCS 5-2009, f. & cert. ef. 12-22-09; Suspended by OHCS 13-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-055-0105
General Administrative and Monitoring Requirements

(1) A recipient of GHAP funds shall submit to the Department annually a report satisfactory to the Department for the purpose, inter alia, of compliance monitoring by same. The recipient shall submit such other information as the Department may from time to time require.

(2) A recipient of GHAP funds is subject to reviews and field inspections that the Department determines to be necessary or appropriate including, but not limited to ensuring the recipient's and project owner's compliance with program requirements including, but not limited to OAR chapter 813 (including the GHAP Manual and General Manual), Department directives, funding documents, or otherwise. The recipient and project owner shall cooperate fully with all reviews and field inspections, timely comply with any resulting correction directives, and make all records available for inspection and copying.

(3) A recipient of GHAP assistance or owner of a project receiving such assistance shall retain financial records, supporting documents and all other pertinent records for six years after the project affordability period is complete, or after any litigation or audit claim is resolved, whichever is later.

Stat. Auth.: ORS 456.555, 458.665
Stats. Implemented: ORS 456.515 - 456.725, 458.665
Hist.: OHCS 5-2009, f. & cert. ef. 12-22-09; Renumbered from 813-055-0080, OHCS 7-2013, f. & cert. ef. 6-21-13; OHCS 13-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-055-0110
Waiver

The Director may waive or modify any requirements of these Program rules, unless such waiver or modification would violate applicable federal or state statutes or regulations.

Stat. Auth.: ORS 456.515 - 456.725 & 458.600 - 458.660
Stats. Implemented: ORS 458.660
Hist.: OHCS 5-2009, f. & cert. ef. 12-22-09; Suspended by OHCS 13-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-055-0115
Remedies

(1) If the Department determines that there has been any material failure or default with respect to any term, covenant or condition of the solicitation or funding documents, applicable rules, directives, other program requirements, or otherwise, it may exercise any remedy available to it under any program requirements including, but not limited to OAR chapter 813 (including, but not limited to the HDGP Manual and General Manual), relevant solicitation or funding documents, or applicable law. Remedies include, but are not limited to corrective orders or directives, rescission, termination of assistance, recoupment of HDGP funds and other Department assistance already disbursed with respect to a project – including with applicable interest, recovery for damages, specific performance, injunctive relief, declaratory actions, appointment of a receiver for the project, foreclosure of lien interests, debarment from Department assistance, and other remedies available at law or otherwise.

(2) A material default has occurred, inter alia, if:

(a) The recipient or project owner has not commenced any significant aspect of the project activities within six months after the award of project funding;

(b) The recipient or project owner has not entered into any necessary third party agreement related to the project within ninety (90) days of the award of project funding;

(c) The recipient or project owner has used HDGP funds for activities not approved in these rules, solicitation or funding documents, or other HDGP program requirements;

(d) The recipient or project owner has not completed activities required by these rules, solicitation or funding documents, or other HDGP program requirements in a timely manner;

(e) The recipient or project owner has not complied with any and all affordability, habitability and monitoring compliance obligations required in these rules, solicitation or funding documents, or other HDGP program requirements; or

(f) The recipient or project owner lacks continued capacity to carry out any and all obligations under these rules, solicitation or funding documents, or other HDGP program requirements.

(3) The remedies set forth in this section are cumulative and not exclusive and are in addition to any other rights and remedies provided in this Division, other Department rules, the solicitation or funding documents, or otherwise available at law or otherwise. The Department may

exercise any or all remedies available to it, and in such manner as it, in its sole discretion, determines appropriate.

(4) A recipient or project owner shall take all action necessary to enforce all terms of any agreement with a third party in furtherance of its obligations to the Department where such third party materially fails to comply with the terms of such agreement and shall act to recover on behalf of the Department any costs, expenses and damages that may arise as a result of the breach of the agreement. The recipient, by its execution of its funding documents with the Department regardless of whether the agreement expressly so states, acknowledges and agrees that the Department at its sole discretion may:

(a) Enforce the terms of any agreement the recipient has with a third party regarding the program or project; or

(b) Recover any sums that become due as the result of a breach of the agreement.

Stat. Auth.: ORS 456.555, 458.665
Stats. Implemented: ORS 456.515 - 456.725, 458.665
Hist.: OHCS 5-2009, f. & cert. ef. 12-22-09; Renumbered from 813-055-0090, OHCS 7-2013, f. & cert. ef. 6-21-13; OHCS 13-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

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Rule Caption: Amends common terms, policies and procedures used in Department programs.
Adm. Order No.: OHCS 14-2013(Temp)
Filed with Sec. of State: 6-21-2013
Certified to be Effective: 6-21-13 thru 12-18-13
Notice Publication Date:
Rules Adopted: 813-005-0020, 813-005-0030, 813-005-0040, 813-005-0050, 813-005-0060, 813-005-0070
Rules Amended: 813-005-0001, 813-005-0005, 813-005-0016
Subject: The General Rules accomplish the general purpose of describing certain common terms, policies and procedures with respect to the administration of the Department. The department has completed a significant reorganization as to how it solicits and administers funding awards for this program as part of the restructure. These rule changes are designed to reflect a significant reorganization of the department.
Rules Coordinator: Sandy McDonnell—(503) 986-2012

813-005-0001
General Purpose

OAR chapter 813, division 005, is promulgated to accomplish the purpose of describing certain common terms, policies and procedures with respect to the administration of the Housing and Community Services Department.

Stat. Auth.: ORS 90.630, 90.771 - 90.775, 90.800 - 90.840, 183, 315.271, 317.097, 446.525 - 446.543, 456.515 - 456.725, 458.210 - 458.365, 458.405 - 458.460, 458.505 - 458.740, 566.310 - 566.350 & 757.612 - 757.617
Stats. Implemented: ORS 90.630, 90.771 - 90.775, 90.800 - 90.840, 183, 315.271, 317.097, 446.525 - 446.543, 456.515 - 456.725, 458.210 - 458.365, 458.405 - 458.460, 458.505 - 458.740, 566.310 - 566.350 & 757.612 - 757.617
Hist.: OHCS 1-2005(Temp), f. & cert. ef. 8-4-05 thru 1-31-06; OHCS 3-2006, f. & cert. ef. 1-31-06; OHCS 14-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-005-0005
Definitions

(1) Terms used in OAR chapter 813 have the meanings given them in the Act, in this section, otherwise in OAR chapter 813 or in other applicable law, unless the context indicates to the contrary. Such terms need not be capitalized. Undefined terms are intended to be read consistently with their normal usage unless the context indicates otherwise.

(2) Pursuant to ORS 456.555(5)(b) the Housing and Community Services Department by administrative rule, must identify and distinguish between housing programs and community services programs. Any program administered by the Department (as principal and not agent) that is not listed in this subsection, does not principally involve the financing, regulation, maintenance or support of housing or home ownership or otherwise defined in statute or in this chapter as a housing program is a "community service program." Accordingly, the following programs administered by the department are housing programs:

(a) Multi-Unit Housing Program (OAR 813-010);
(b) Rental Housing Program (OAR 813-012);
(c) Oregon Rural Rehabilitation Program (OAR 813-015);
(d) Single-Family Mortgage Program (OAR 813-020);
(e) Elderly Housing Program (OAR 813-030);
(f) Pass-Through Revenue Bond Financing Program (OAR 813-035);
(g) Pre-Development Program (OAR 813-038);
(h) Farmworker Housing Development Account (OAR 813-039);
(i) Seed Money Advance Program (OAR 813-040);
(j) Farmworker Housing Tax Credit Program (OAR 813-041);
(k) Housing Development Program (OAR 813-042);
(l) Housing Loan Guarantee Program (OAR 813-043);
(m) Homeownership Assistance Program (OAR 813-044);
(n) Housing Development Account Program (813-045);
(o) Emergency Housing Program (OAR 813-046);
(p) Housing Revitalization Program (OAR 813-048);
(q) Disabled Housing Program (OAR 813-060);
(r) Home Improvement Loan Program (OAR 813-070);
(s) Mortgage Credit Certificate Program (OAR 813-080);
(t) Low-Income Housing Tax Credit Program (OAR 813-090);
(u) Oregon Affordable Housing Tax Credit Program (OAR 813-110);
(v) Home Investment Partnerships Program (OAR 813-120);
(w) HELP Program (OAR 813-130);
(x) Incentive Fund Program (OAR 813-140);
(y) Subsidized Development Visitability Program (OAR 813-310);
(z) General Guarantee Program (OAR 813-350); and

(aa) Other activities of the Department involving the financing, regulation, maintenance or support of housing or home ownership or that otherwise are defined in statute or in this chapter as a housing program.

(3) Pursuant to ORS 456.555, the Housing and Community Services Department is to establish from time to time, by administrative rule, the threshold property purchase price at which a single-family home ownership loan on property must be submitted by the Department to the State Housing Council for approval or disapproval as well as the threshold value for a housing grant or other housing funding award for multifamily housing. Presently, the threshold property purchase price for single-family home ownership that obligates the Department to obtain State Housing Council review and approval of a proposed single-family loan is that purchase price which, when reduced by costs of purchase other than the Department loan, is equal to or greater than seventy-five percent of the applicable area program purchase price limit or $190,000, whichever is greater. The threshold value of a housing grant or other housing funding award with respect to a multifamily housing development (Project) that obligates the Department to obtain State Housing Council review and approval is $200,000 per funding source with an aggregate threshold per Project of $400,000.

(4) "Acquisition Loan" means a Loan for the purpose of financing the purchase of an existing Project.

(5) "Act" means ORS 456.515 through 456.725 and, given the context, also may include 458.005 through 458.740, 90.800 through 90.840, and 91.886.

(6) "Approved Lender" means any person authorized to engage in the business of making loans of the general character of Program Loans, who meets the qualifications for an Approved Lender set forth in the applicable Program rules and who contracts with the Department to make Program Loans.

(7) "Approved Servicer" means any person authorized to engage in the business of servicing loans of the general character of Program Loans, who meets the qualifications for an Approved Servicer set forth in the applicable Program rules and who contracts with the Department to service Program Loans.

(8) "Bond" means any bond, note or other evidence of indebtedness issued to obtain funds to provide financing for a Program of the Department as provided in the Act or as further defined by statute.

(9) "Borrower" means an Eligible Borrower who has received a Program Loan.

(10) "Break-Even Occupancy" means the point in time when a Project's monthly rental income meets its monthly operating expenses and debt service.

(11) "Commitment" means the written conditional obligation of the Department to make, purchase, service or sell a Program Loan or other funding award.

(12) "Community Service Programs" are defined in subsection (2) of this section.

(13) "Contingency Escrow Account" means an account generally not to exceed 3% of the initial principal amount of the Program Loan, established by the Sponsor in the form of a savings account, time certificate of deposit, or irrevocable letter of credit assigned to the Department.

(14) "Cooperative" is a consumer housing entity formed according to the provisions of ORS Chapter 62, as amended.

(15) "Department" means the Housing and Community Services Department of the State of Oregon established pursuant to ORS 456.555

originally enacted by Enrolled House Bill 3377, Chapter 739, Oregon Laws 1991.

(16) "Director" means the chief administrative officer of the Housing and Community Services Department established pursuant to ORS 456.555(2).

(17) "Elderly Household" means a household residing in the State of Oregon whose head is over the age of 58 or 55, as applicable.

(18) "Eligible Borrower" means a person who satisfies the criteria to receive a Program Loan as set forth in the applicable Program rules, statutes or Department orders.

(19) "Escrow Payments" means the monthly payments made by the Sponsor or Borrower and placed in an escrow reserve account for the payment of property taxes, insurance premiums and reserve for replacements and other identified costs as required by the Department in accordance with the Program Loan.

(20) "Funding Documents" means any and all documents required by the Department to document a housing grant or other funding award or reservation commitment including, but not limited to Loan Agreements, Regulatory Agreements, Operating Agreements, reservation letters, guarantees or otherwise.

(21) "Housing Council" or "State Housing Council" means that seven-member body established by ORS 456.

(22) "Housing Programs" are defined in subsection (2) of this section.

(23) "Lending Department" means a commercial bank, savings and loan association, savings bank, mortgage banker Federal Housing Administration, Farmers Home Administration or other department that provides permanent or construction mortgage loans.

(24) "Loan Agreement" means a written agreement, typically executed at Loan Closing, between the Department and a Sponsor establishing the terms of any Department Loan.

(25) "Loan Closing" means the disbursement by the Department of the Program Loan proceeds after execution and recording of the Loan Documents.

(26) "Loan Documents" means the written agreements by and between the Sponsor and the Department or in favor of the Department, typically executed at Loan Closing, and generally including, but not necessarily limited to the Promissory Note, the Loan Agreement, the Trust Deed and the Regulatory Agreement.

(27) "Mobile Home Park" means a Project consisting of individual lots and mobile homes located within 500 feet of one another on a lot, tract or parcel of land under the same ownership, and which complies with all ordinances, plans and codes in the area.

(28) "NOFA" means a Notice of Funding Availability.

(29) "Operating Agreement and Declaration of Restrictive Covenants and Equitable Servitudes" or "Operating Agreement" means a written agreement typically executed at Loan Closing between the Department and the Sponsor of a Project under the Department's Pass-Through Revenue Bond Program and regulating the use of revenues and operation of the Project, particularly with respect to tenant income and unit rent compliance by the Sponsor.

(30) "Person" means any natural or legal person.

(31) "Procedural Guide" means a manual of written procedures adopted by the Department to carry out a Program.

(32) "Program" means a statutorily authorized plan or order of business conducted by the Department.

(33) "Program Loan" means a loan made pursuant to a Program of the Department.

(34) "Program Requirements" means the requirements with respect to any Department funding program including but not limited to as contained in or arising from applicable administrative rules, solicitation documents, funding documents, Department directives, federal, state and local statutes, codes, regulations or determinations and other applicable law.

(35) "Qualified Insurer" means the Federal Housing Administration, the Veterans' Administration, or any other person who is authorized to insure or guarantee payment of loans and who is approved by the Department.

(36) "Regulatory Agreement and Declaration of Restrictive Covenants and Equitable Servitudes" or "Regulatory Agreement" means a written agreement typically executed at Loan Closing between the Department and a Sponsor regulating the use of revenues and operation of the Project for which a Department Loan is issued, particularly pertinent with respect to compliance by the Sponsor with maintaining the status of any involved bond issue.

(37) "Rent-Up Reserve Account" means an account set up by the Sponsor and under the control of the Department to assure sufficient funds to pay operating expenses and debt service of the Project before Break-Even Occupancy.

(38) "Replacement Cost Reserve Account" means an account established to aid in payment for extraordinary maintenance or repair of a Project or for replacement of capital items of a Project as allowed by the Department.

(39) "Seed Money Advance" means an advance given to a Qualified Housing Sponsor to pay Preconstruction Costs.

(40) "Single-Family Residence" means a housing unit intended and used for occupancy by one household and the property on which it is located. This shall be real property located in the State of Oregon. A Single-Family Residence may include a single-family residence, condominium unit, a dwelling in a Planned Unit Development (PUD), or a mobile or manufactured home which has a minimum of 400 square feet of living space and a minimum width in excess of 102 inches and is of a kind customarily used at a fixed location.

(41) "Solicitation" means a process by which the Department invites applications for a housing grant or other funding award with respect to a Project.

(42) "Solicitation Documents" means those documents that, inter alia, set forth the terms and conditions of a Solicitation.

(43) "Sponsor" means any Person meeting the legal, financial, credit and other qualifications to be the borrower on a Department Loan and to own and operate a Project as set forth in the applicable Program rules, statutes and Department orders.

(44) "Targeted Area" means an area in the state designated by the Department in compliance with the requirements of Section 143(j) of the Internal Revenue Code of 1986, as amended, and approved by the United States Departments of Treasury and Housing and Urban Development.

(45) "Trustee" means the State Treasurer or, with the approval of the Department, a private financial institution in Oregon acting pursuant to an indenture of trust or other appropriate instrument.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 90.630, 90.771 - 90.775, 90.800 - 90.840, 183, 315.271, 317.097, 446.525 - 446.543, 456.515 - 456.725, 458.210 - 458.365, 458.405 - 458.460, 458.505 - 458.740, 566.310 - 566.350 & 757.612 - 757.617

Stats. Implemented: ORS 456.515 - 456.720

Hist.: 1HD 7-1984, f. & ef. 9-4-84; HSG 1-1987(Temp), f. & ef. 2-5-87; HSG 5-1987, f. & ef. 3-10-87; Renumbered from 813-001-0006; HSG 3-1989(Temp), f. & cert. ef. 6-8-89; HSG 5-1989, f. & cert. ef. 11-3-89; HSG 2-1991(Temp), f. & cert. ef. 8-7-91; HSG 8-1991, f. & cert. ef. 12-23-91; OHCS 1-2005(Temp), f. & cert. ef. 8-4-05 thru 1-31-06; OHCS 3-2006, f. & cert. ef. 1-31-06; OHCS 14-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-005-0016
Waiver

The Director may waive, suspend or modify any term or provision of OAR 813, unless such waiver, suspension or modification would violate applicable federal or state law.

Stat. Auth.: ORS 91.886, 183 & 456.555

Stats. Implemented: ORS 90.800 - 90.840, 91.886, 456.515, 456.725 & 458.005 - 458.740

Hist.: OHCS 1-2005(Temp), f. & cert. ef. 8-4-05 thru 1-31-06; OHCS 3-2006, f. & cert. ef. 1-31-06; OHCS 14-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-005-0020
General Policy and Guideline Manual

The General Policy and Guideline Manual dated June 19, 2013, is incorporated into this Division by reference and has application, inter alia, to the solicitation, review, reservation, award and documentation of housing grants and other funding awards with respect to affordable multifamily housing projects as well as to the operation and compliance of such projects with applicable habitability, affordability and other requirements irrespective of the program source of funding.

Stat. Auth.: ORS 91.886, 317.097 & 456.555

Stats. Implemented: ORS 90.800 - 90.840, 91.886, 317.097, 456.515 - 456.725 & 458.005 - 458.740

Hist.: OHCS 14-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-005-0030
Contingency of Funding Awards

If the Department provides a reservation or otherwise commits to make a funding award under ORS 90.800 — 90.840, 91.886, 317.097, 456.515 — 456.725 or 458.005 — 458.740, and if the type and amount of subject funding or any other Department funding approved by the Department that was considered by the Department in setting the amount of the subject funding ("Complementary Funding") meets or exceeds the threshold amounts established in OAR 813-005-0005(3) for review by the State Housing Council, the reservation or other commitment is subject to review and approval by the Council of such subject funding and any such Complementary Funding. The Council may approve, deny, modify or further condition funding assistance subject to its review. Based upon any rel-

evant Council determination, including with respect to Complementary Funding, any subject reservation or other commitment may be deemed revoked, or be modified and further conditioned.

Stat. Auth.: ORS 91.886, 317.097 & 456.555
Stats. Implemented: ORS 90.800 - 90.840, 91.886, 317.097, 456.515 – 456.725 & 458.005 - 458.740
Hist.: OHCS 14-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-005-0040
Compliance Monitoring

(1) A project receiving any Department assistance is subject to such reviews and field inspections that the Department determines to be necessary or appropriate including, but not limited to ensuring the funding recipient's and project owner's compliance with any program requirements including, but not limited to applicable administrative rules (including incorporated manuals), Department directives, solicitation documents, funding documents, or otherwise. The project owner shall cooperate fully with all reviews and field inspections, comply with any resulting correction directives, and shall make all records available for inspection and copying. The project owner also shall provide such other information as the Department may from time to time request.

(2) Project owners shall cooperate fully with Department reviews, field inspections and other information requests including, but not limited to allowing the inspection and copying of relevant records as determined by the Department.

(3) Project owners shall act promptly to correct any deficiencies identified by the Department as a consequence of its reviews, field inspections or otherwise upon notice by the Department of same.

(4) Project owners shall retain financial records, supporting documents and all other pertinent records with respect to a project until six years after the project affordability period for the respective source of funding is complete, or after any relevant litigation or audit claim is resolved, whichever is later.

Stat. Auth.: ORS 91.886, 317.097 & 456.555
Stats. Implemented: ORS 90.800 - 90.840, 91.886, 317.097, 456.515 – 456.725 & 458.005 - 458.740
Hist.: OHCS 14-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-005-0050
Remedies

(1) If the Department determines that there has been any material failure or default with respect to any term, covenant or condition of the applicable solicitation documents or funding documents, applicable rules, directives, or other program requirements, it may exercise any remedy available under OAR chapter 813, the solicitation documents, the funding documents, other program requirements or applicable law. Remedies include, but are not limited to rescission of funding awards, issuance of corrective orders or directives, imposition of sanctions, recapture of any tax credits, recoupment of funding, recovery for damages, specific performance, injunctive relief, declaratory actions, appointment of a receiver for the project, foreclosure of lien interests, debarment from other Department funding, and other remedies available at law.

(2) The remedies set forth in this section are cumulative and not exclusive and are in addition to any other rights and remedies available to the Department. The Department may exercise any or all remedies available to it, and in such manner as it, in its sole discretion, determines appropriate. No failure to exercise a remedy shall be deemed as a waiver or release of such remedy or other remedies or the claims upon which they are based.

(3) Any waiver of a remedy or claim must be in writing and signed by an authorized representative of the Department. No waiver shall be continuing in nature or affect any other remedy or claim of the Department unless expressly so stated in the signed waiver.

Stat. Auth.: ORS 91.886, 317.097 & 456.555
Stats. Implemented: ORS 90.800 - 90.840, 91.886, 317.097, 456.515 – 456.725 & 458.005 - 458.740
Hist.: OHCS 14-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-005-0060
Transfer of Recipient, Assistance or Ownership; Subordinate Liens; Encumbrances

(1) A recipient of any Department assistance or owner of a project for which such assistance is provided may not transfer or allow any transfer of any interest in itself, the assistance or the project, allow a subordinate lien or otherwise encumber the project, or any portion or interest therein, unless the Department first approves the transfer, subordinate lien or encumbrance in writing. Any such transfer is subject to the payment to the Department of a transfer or other approval charge as required by the Department. If the recipient effects or allows a transfer, subordinate lien or encumbrance without prior written approval by the Department, the transfer, subordinate lien or encumbrance is voidable and remains subject to the approval or disapproval of the Department and the recipient or owner responsible for allowing the transfer, subordinate lien or encumbrance and any transferees, jointly and severally, are subject to a charge by the Department with respect to its review and treatment of any such event.

(2) The Department may condition its approval upon such terms and conditions as it, in its sole discretion, may require. Factors the Department may consider in determining whether or not to give approval to a transfer, subordinate lien or encumbrance include, but are not limited to:

(a) The financial investment of the Department in the project;

(b) Preservation of existing housing;

(c) The transferee's ability to maintain and manage the project for the needs of the residents, the integrity of the housing and as security for the assistance;

(d) The effect of the transfer, subordinate lien or encumbrance upon the financial integrity of the project, repayment of the assistance, use of the project for its intended purposes, and continuity of the program requirements; and

(e) Continued compliance with program requirements.

Stat. Auth.: ORS 91.886, 317.097 & 456.555
Stats. Implemented: ORS 90.800 - 90.840, 91.886, 317.097, 456.515 – 456.725 & 458.005 - 458.740
Hist.: OHCS 14-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-005-0070
Fees and Charges

The Department may require the payment of such fees and charges as it determines appropriate with respect to the administration of its housing programs and program requirements including, but not limited to the solicitation, award, documentation and use of Department funding assistance and correlation with other funding partners and resources, acquisition, development, construction, rehabilitation and operation of projects assisted with Department funding assistance, ongoing compliance monitoring and enforcement of financial, affordability, and habitability requirements, transfers, subordinate liens and encumbrances.

Stat. Auth.: ORS 91.886, 317.097 & 456.555
Stats. Implemented: ORS 90.800 - 90.840, 91.886, 317.097, 456.515 – 456.725 & 458.005 - 458.740
Hist.: OHCS 14-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

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Rule Caption: Amends the process for soliciting and administering funding awards for the HELP Program.
Adm. Order No.: OHCS 15-2013(Temp)
Filed with Sec. of State: 6-21-2013
Certified to be Effective: 6-21-13 thru 12-18-13
Notice Publication Date:
Rules Amended: 813-130-0000, 813-130-0010, 813-130-0020, 813-130-0030, 813-130-0040, 813-130-0050, 813-130-0060, 813-130-0070, 813-130-0080, 813-130-0090, 813-130-0100, 813-130-0110, 813-130-0120, 813-130-0150
Rules Suspended: 813-130-0130, 813-130-0140
Subject: The HELP Program provides financial assistance for the construction, acquisition and/or rehabilitation of multifamily rental housing for individuals and families of very low income in order to expand the supply of affordable, decent, safe and sanitary housing in Oregon. The department has completed a significant reorganization as to how it solicits and administers funding awards for this program as part of the restructure. These rule changes are designed to reflect the significant reorganization of the department.
Rules Coordinator: Sandy McDonnell—(503) 986-2012

813-130-0000
Purpose and Objectives

OAR chapter 813, division 130, is promulgated to carry out the provisions of the HELP Program. The Department receives HELP funds from the U.S. Department of Housing and Urban Development (HUD) under Section 1012 of the Steward B. McKinney Homeless Assistance Act ("the McKinney Act") of 1988. The HELP Program is funded by monies realized from the HUD-authorized refunding of existing bonds issued by the Department, the proceeds of which were originally used to finance housing projects, pursuant to an agreement between the Department and HUD under HUD's Financing Adjustment Factor (FAF) Program. Under the FAF Program, HUD shares such monies realized from these refundings on an

equal basis with bond issuers such as the Department, and attaches certain restrictions and requirements upon the use of funds realized from such refunding. The HELP Program's purpose is to provide financial assistance for the construction, acquisition and/or rehabilitation of multifamily rental housing for individuals and families of very low income in order to expand the supply of affordable, decent, safe and sanitary housing in Oregon. Additional Program policies and instructions are outlined in the HELP Program Policies and Guidelines Manual dated June 21, 2013 (the "HELP Manual" or "Manual"), incorporated herein by reference. The Manual may be accessed online on the Department's website.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.555, 456.559, 456.625
Hist.: HSG 6-1993(Temp), f. & cert. ef. 10-1-93; HSG 4-1994, f. & cert. ef. 8-1-94; OHCS 12-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 11-2007, f. & cert. ef. 1-11-07; OHCS 15-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-130-0010
Definitions

Certain terms used in OAR chapter 813, division 130, are defined in the Act, OAR 813-005-0005, and herein. Other terms may be identified in the text of this division (including by incorporation), otherwise in chapter 813, or applicable law. As used in OAR chapter 813, division 130, unless the context indicates otherwise:

(1) "Affordability period" means the period during which a Project assisted with HELP funds must remain affordable to very low income residents, which period shall be at least 10 years from the date of the use agreement executed in favor of the Department.

(2) "Annual household income" means the anticipated total income from all sources received by the family head and by each additional member of the family of 18 years of age and over, including all net income derived from assets for the twelve-month period following the effective date of certification of income, in accordance with HUD regulations, 24 CFR 813.

(3) "Applicant" means an applicant for HELP funds.

(4) "Household" means one or more persons occupying a housing unit.

(5) "HUD" means the U.S. Department of Housing and Urban Development.

(6) "Low income" means annual household income that does not exceed 80 percent of the median household income for the area, as determined by HUD, with allowances for family size.

(7) "Nonprofit organization" means

(a) An organization that has obtained tax-exempt status under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, and is established under the provisions of ORS Chapter 65,

(b) A community development corporation as defined in ORS 458.210,

(c) A housing authority as defined in ORS 456.005,

(d) A community action agency established pursuant to the federal Economic Opportunity Act of 1964, which meets the requirements of ORS 458.505(4), or

(e) Other nonprofit entity satisfactory to the Department and representing or seeking to serve the housing, human services and community economic revitalization needs of a clearly-defined population and area.

(8) "Program" means the HELP Program.

(9) "Project" means a multifamily rental housing development assisted or to be assisted, in part, with HELP Program funds.

(10) "Recipient" means a recipient of HELP funds to be used for Project assistance.

(11) "Use agreement" means the Financing Adjustment Factor Savings Funds Use Agreement between a Recipient and the Department.

(12) "Very low income" means annual household income that does not exceed 50 percent of the median household income for the area, as determined by HUD, with allowances for family size.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.555, 456.559, 456.625
Hist.: HSG 6-1993(Temp), f. & cert. ef. 10-1-93; HSG 4-1994, f. & cert. ef. 8-1-94; OHCS 12-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 11-2007, f. & cert. ef. 1-11-07; OHCS 15-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-130-0020
Eligible Applicants for HELP Funds

Eligible recipients for HELP funds include units of general local government and nonprofit organizations that propose to construct, acquire and/or rehabilitate projects with rental housing units for very low income tenants.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.555, 456.559, 456.625
Hist.: HSG 6-1993(Temp), f. & cert. ef. 10-1-93; HSG 4-1994, f. & cert. ef. 8-1-94; OHCS 12-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 11-2007, f. & cert. ef. 1-11-07; OHCS 15-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-130-0030
Eligible Activities for HELP Funds

HELP funds provided by the Department shall be used for the construction, acquisition and/or rehabilitation of projects with rental housing units for very low income tenants.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.555, 456.559, 456.625
Hist.: HSG 6-1993(Temp), f. & cert. ef. 10-1-93; HSG 4-1994, f. & cert. ef. 8-1-94; OHCS 12-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 11-2007, f. & cert. ef. 1-11-07; OHCS 15-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-130-0040
Eligible Costs for HELP Funds

Project costs eligible for HELP assistance are costs that promote housing affordability and include, but are not limited to:

(1) Development hard costs, such as the actual costs of constructing or rehabilitating rental housing;

(2) Costs of acquiring improved or unimproved real property;

(3) Pre-development costs which have been pre-approved by the Department;

(4) Soft development costs associated with the construction, acquisition, or rehabilitation, including fees and interest studies; and

(5) Other uses identified in the HELP Manual.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.555, 456.559, 456.625
Hist.: HSG 6-1993(Temp), f. & cert. ef. 10-1-93; HSG 4-1994, f. & cert. ef. 8-1-94; OHCS 12-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 11-2007, f. & cert. ef. 1-11-07; OHCS 15-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-130-0050
HELP Affordability Requirements

(1) A use agreement executed by the Department and a recipient shall include covenants and restrictions running with land (that will be binding upon the recipient and any successors in title to the project) that require such Project to remain affordable to very low income residents during the affordability period.

(2) Use agreements, *inter alia,* will require recipients or other project owners to obtain resident income certifications at the time of initial occupancy of the HELP-assisted units and on an annual basis thereafter during the affordability period to document to the Department that units assisted with HELP funds continue to serve very low income tenants.

(3) Use agreements, *inter alia,* may provide that a tenant household with very low income at the time of initial occupancy will remain eligible despite the rise of household income and will not be displaced by reason of ceasing to qualify as a very low income family or person if the owner exercises reasonable efforts to lease the next available similar unit in the project to a family or person of very low income.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.555, 456.559, 456.625
Hist.: HSG 6-1993(Temp), f. & cert. ef. 10-1-93; HSG 4-1994, f. & cert. ef. 8-1-94; OHCS 12-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 11-2007, f. & cert. ef. 1-11-07; OHCS 15-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-130-0060
Program Requirements

The Department has developed policies and guidelines for the HELP Program, which supplement Division 120 and 24 CFR 813. These policies and guidelines are contained in the HELP Manual and further address application procedures, project eligibility, project selection criteria, financial assistance available, and other applicable information. Other applicable chapter 813 rules, Department directives, and the terms of required funding documents also apply.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.555
Hist.: HSG 6-1993(Temp), f. & cert. ef. 10-1-93; HSG 4-1994, f. & cert. ef. 8-1-94; OHCS 12-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 11-2007, f. & cert. ef. 1-11-07; OHCS 15-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-130-0070
Distribution of Funds

The Department shall distribute HELP funds according to the Program administrative rules for the targeted clients as endorsed by the Housing Council and in accordance with Program application materials.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.555, 456.559, 456.625
Hist.: HSG 6-1993(Temp), f. & cert. ef. 10-1-93; HSG 4-1994, f. & cert. ef. 8-1-94; OHCS 12-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 11-2007, f. & cert. ef. 1-11-07; OHCS 15-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-130-0080
Application Procedure and Requirements

(1) The process to obtain HELP assistance typically will be spelled out in the solicitation documents issued by the Department. In addition to, or in lieu of formal solicitation documents, the Department may provide other means for accessing HELP assistance. Additional direction and guidance may be found in the HELP Manual and General Manual.

(2) The Department may require payment of a non-refundable application charge from any applicant requesting HELP funds through a formal solicitation or otherwise.

(3) The Department may require payment of other charges with respect to its reasonably anticipated costs in processing applications, coordinating programs or with other project participants, providing funding, negotiating documents, monitoring compliance, evaluating and documenting transfers, or otherwise. The Department may require payment of a supplemental application charge from applicants requesting additional resources for projects that have already been funded by the Department.

(4) The Department may refuse to process applications or terminate processing if it determines an application to be incomplete or that fail it fails to satisfy threshold standards for further processing.

(5) An applicant shall submit to the Department, on the application form and in accordance with the application process prescribed by the Department, such information as the Department may require, including but not limited to:

(a) Name, address and telephone number of applicant;

(b) Type of assistance requested;

(c) A written description of the project, including the number of units, unit mix, proposed rents, site location, amenities, and any other information requested by the Department.

(d) A statement of project purpose indicating the housing type and residents to be housed, and the length of the affordability period;

(e) One or more pro forma of project income and expenses;

(f) The amount of funding requested and total project development costs, including a description and documentation of all project funding sources and uses;

(g) A narrative of the applicant's experience in developing affordable housing, including the experience of all members of the project development team;

(h) A narrative of the experience of the applicant's management team or agent as it relates to operating affordable housing projects;

(i) A description of resident services to be provided;

(j) A narrative of the applicant's experience in providing resident services, including the experience of any relevant project team members;

(k) A description of the applicant's readiness to proceed with project activities; and

(l) A schedule for completion of project activities.

(6) The Department may restrict the amount and/or type of assistance available in any solicitation or other provision of assistance and restrict the type or number of applicants or recipients eligible for assistance in a particular funding process.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.555, 456.559, 456.625
Hist.: HSG 6-1993(Temp), f. & cert. ef. 10-1-93; HSG 4-1994, f. & cert. ef. 8-1-94; OHCS 12-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 11-2007, f. & cert. ef. 1-11-07; OHCS 15-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-130-0090
Application Review

(1) An application for assistance from the HELP program is subject to the Department's evaluation and approval or disapproval according to criteria in the solicitation documents or otherwise that may include, but are not limited to the following:

(a) The amount of available funds in the HELP Program;

(b) The availability of other sources of assistance;

(c) The applicant's efforts to leverage other public or private funds;

(d) Whether the project is financially feasible and the financial strength and history of the prospective recipient;

(e) The location of the project site, including its proximity to transportation, shopping, social, commercial and recreational facilities, medical services and such other facilities and services that best serve the residents;

(f) Availability of street, sewer, water, utilities and other public services;

(g) Architectural design, including aesthetic quality, soundness of construction, energy efficiency, and suitability to the needs of the residents to be served;

(h) Whether or not the project will include fee ownership of the real property;

(i) Compliance with applicable local comprehensive plan and land use regulations, housing codes and other applicable standards;

(j) Market demand;

(k) The target population to be served;

(l) The experience of the developer, contractors, architects, consultants and management agent in developing, constructing and operating housing projects;

(m) The Department's experience with and the reputation, experience, capacity and legal history and status of the applicant and its agents, representatives, employees and contractors;

(n) Whether the project in comparison to others best achieves the purposes of the HELP Program; and

(o) Other factors that the Department determines to be relevant including, but not limited to any evaluation criteria in the solicitation documents, HELP Manual, General Manual, or otherwise.

(2) If the Department approves an application in whole or in part and if the amount of the HELP assistance or any other Department funding approved by the Department that was considered by the Department in setting the amount of HELP assistance to be provided ("Complementary Funding") meets or exceeds the threshold amount established in OAR 813-001-0007(1) for review by the State Housing Council, the approval of HELP assistance by the Department is subject to review and approval by the Council of such HELP funding and any such Complementary Funding. The Council may approve, deny, modify or further condition funding subject to its review. Based upon any relevant Council determination, including with respect to Complementary Funding, approval of HELP funding may be deemed revoked, or be modified and further conditioned.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.555, 456.559, 456.625
Hist.: HSG 6-1993(Temp), f. & cert. ef. 10-1-93; HSG 4-1994, f. & cert. ef. 8-1-94; OHCS 12-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 11-2007, f. & cert. ef. 1-11-07; OHCS 15-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-130-0100
Form of Assistance; Documentation

(1) The Department may provide HELP funds in the form of a grant or a loan, or a combination of both. Loan rates and terms, if applicable shall be determined by the Department based on a project's needs and cash flow, other funding resources, market conditions and an applicant's capacity to repay HELP funds. Preference will be given to those applicants requesting loans that show sufficient project cash flow to repay the loan. The Department normally will notify an applicant in a written reservation letter as to the amount and form of HELP assistance, if any, to be provided, together with notable conditions. Such reservation commitments remain subject to Department rules, solicitation requirements, applicable law, and the negotiation, execution and recording (if required) of documents satisfactory to the Department.

(2) Each recipient shall, inter alia, execute a use agreement, containing such terms regarding fees, interest rates, repayment terms, performance criteria, reporting requirements, restrictive covenants, and other terms as the Department or HUD considers appropriate or necessary for the type and use of assistance provided. Each use agreement must be:

(a) (If the recipient owns the project property at the time of disbursement) recorded as an encumbrance on the project property before any HELP funds are advanced; or

(b) If the recipient does not own the project property at the time of disbursement HELP funds, at the discretion of the Department, may be placed in escrow in an escrow account established by the recipient satisfactory to the Department, and subject to such further conditions as the Department may require, including the recording of restrictive covenants running with the project property for the applicable affordability period with appropriate lien priority and taking effect upon close of escrow.

(3) The Department may require a recipient to execute and record such documents satisfactory to the Department as it considers appropriate in its sole discretion.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.555, 456.559, 456.625
Hist.: HSG 6-1993(Temp), f. & cert. ef. 10-1-93; HSG 4-1994, f. & cert. ef. 8-1-94; OHCS 12-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 11-2007, f. & cert. ef. 1-11-07; OHCS 15-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-130-0110
General Administrative and Monitoring Requirements

(1) The Department and HUD may perform such reviews or field inspections, including review and copying of documents, as they deem appropriate, inter alia, to ensure program compliance. Project owners must cooperate reasonably with all reviews and field inspections. The

Department and HUD may require that a recipient take such remedial actions as they determine to be appropriate.

(2) Financial records, supporting documents, and all other pertinent records shall be retained by a project owner for five years after the project affordability period is complete, or after any litigation or audit claim is resolved, whichever is later. The Department, HUD, the Inspector General, the General Accounting Office, the Oregon Secretary of State and their representatives shall have access to all books, accounts, documents, records and other property belonging to or in use by the recipient and project owner that relate to the use of HELP funds.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.555, 456.559, 456.625
Hist.: HSG 6-1993(Temp), f. & cert. ef. 10-1-93; HSG 4-1994, f. & cert. ef. 8-1-94; OHCS 12-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 11-2007, f. & cert. ef. 1-11-07; OHCS 15-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-130-0120
Remedies for Noncompliance

(1) If the Department determines that there has been any material failure or default with respect to any term, covenant or condition of the solicitation or funding documents, applicable rules, directives, other program requirements, or otherwise, it may exercise any remedy available to it under OAR chapter 813 (including, but not limited to the HELP Manual and General Manual), relevant solicitation or funding documents, or applicable law. Remedies include, but are not limited to corrective orders or directives, rescission, termination of funding, recoupment of HELP funds and other Department funding already disbursed with respect to a project – including with applicable interest, recovery for damages, specific performance, injunctive relief, declaratory actions, appointment of a receiver for the project, foreclosure of lien interests, debarment from other Department funding, and other remedies available at law.

(2) A material default has occurred, inter alia, if:

(a) The recipient or project owner has not commenced any significant aspect of the project activities within six months after the award of project funding;

(b) The recipient or project owner has not entered into any necessary third party agreement related to the project within ninety (90) days of the award of project funding;

(c) The recipient or project owner has used HELP funds for activities not approved in these rules, solicitation or funding documents, or other HELP Program requirements;

(d) The recipient or project owner has not completed activities required by these rules, solicitation or funding documents, or other HELP Program requirements in a timely manner;

(e) The recipient or project owner has not complied with any and all affordability, habitability and monitoring compliance obligations required in these rules, solicitation or funding documents, or other HELP Program requirements; or

(f) The recipient or project owner lacks continued capacity to carry out any and all obligations under these rules, solicitation or funding documents, or other HELP Program requirements.

(3) The remedies set forth in this section are cumulative and not exclusive and are in addition to any other rights and remedies provided in this Division, other Department rules, the solicitation or funding documents, or otherwise available at law or otherwise. The Department may exercise any or all remedies available to it, and in such manner as it, in its sole discretion, determines appropriate.

(4) A recipient or project owner shall take all action necessary to enforce all terms of any agreement with a third party in furtherance of its obligations to the Department where such third party materially fails to comply with the terms of such agreement and shall act to recover on behalf of the Department any costs, expenses and damages that may arise as a result of the breach of the agreement. The recipient, by its execution of its funding documents with the Department regardless of whether the agreement expressly so states, acknowledges and agrees that the Department at its sole discretion may:

(a) Enforce the terms of any agreement the recipient has with a third party regarding the program or project; or

(b) Recover any sums that become due as the result of a breach of the agreement.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.555, 456.625
Hist.: HSG 6-1993(Temp), f. & cert. ef. 10-1-93; HSG 4-1994, f. & cert. ef. 8-1-94; OHCS 12-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 11-2007, f. & cert. ef. 1-11-07; OHCS 15-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-130-0130
Sanctions

(1) The Department may invoke sanctions against a Recipient that fails to comply with the provisions of its Use Agreement. The following circumstances may warrant sanctions:

(a) HELP funds have not been expended within six months of disbursement by the Department to the Recipient;

(b) There is a material breach of the Use Agreement;

(c) The Use Agreement was not recorded on the property required by OAR 813-130-0100(3) or as agreed; or

(d) The Department finds that significant corrective actions are necessary to protect the integrity of the project funds and those corrective actions are not, or will not be, made within a reasonable time.

(2) One or more of the following sanctions may be imposed by the Department:

(a) Prohibit a Recipient from applying for future HELP assistance or other Department assistance;

(b) Revoke an existing HELP award;

(c) Withhold unexpended HELP funds;

(d) Require return of HELP funds that have been disbursed to the Recipient but not expended by Recipient;

(e) Require repayment of expended HELP funds; and

(f) Invoke other remedies that may be incorporated into the Use Agreement.

(3) Sanctions will not be imposed by the Department until the Recipient has been notified in writing of its deficiencies and given a reasonable time to respond and correct the deficiencies noted. The sanctions and remedies set forth in this OAR 813-130-0130 are cumulative and not exclusive and are in addition to any other rights and remedies provided by law or under the Use Agreement.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.555
Hist.: HSG 6-1993(Temp), f. & cert. ef. 10-1-93; HSG 4-1994, f. & cert. ef. 8-1-94; OHCS 12-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 11-2007, f. & cert. ef. 1-11-07; Suspended by OHCS 15-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-130-0140
Waiver

The Director may waive or modify any requirements of these Program rules, unless such waiver or modification would violate applicable state statute or federal regulations.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.555
Hist.: OHCS 12-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 11-2007, f. & cert. ef. 1-11-07; Suspended by OHCS 15-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

813-130-0150
Transfer of Recipient, Assistance or Ownership; Subordinate Liens; Encumbrances

(1) A recipient of assistance under the HELP Program or owner of a project for which such assistance is provided may not transfer or allow any transfer of any interest in itself, the assistance or the project, allow a subordinate lien or otherwise encumber the project, or any portion or interest therein, unless the Department first approves the transfer, subordinate lien or encumbrance in writing. Any such transfer is subject the payment to the Department of a transfer charge as established by the Department. If the recipient effects or allows a transfer, subordinate lien or encumbrance without prior written approval by the Department, the transfer, subordinate lien or encumbrance is voidable and remains subject to the approval or disapproval of the Department and the recipient or owner responsible for allowing the transfer, subordinate lien or encumbrance and any transferees, jointly and severally, are subject to a charge by the Department with respect to its review and treatment of any such event.

(2) The Department may condition its approval upon such terms and conditions as it, in its sole discretion, may require. Factors the Department may consider in determining whether or not to give approval to a transfer, subordinate lien or encumbrance include, but are not limited to:

(a) The financial investment of the Department in the project;

(b) Preservation of existing housing;

(c) The transferee's ability to maintain and manage the project for the needs of the residents, the integrity of the housing and as security for the assistance;

(d) The effect of the transfer, subordinate lien or encumbrance upon the financial integrity of the project, repayment of the assistance, use of the project for its intended purposes, and continuity of the program; and

(e) Continued compliance with applicable state and federal laws, rules and regulations.

Stat. Auth.: ORS 456.555

Stats. Implemented: ORS 456.555, 456.559, 456.625
Hist.: HSG 6-1993(Temp), f. & cert. ef. 10-1-93; HSG 4-1994, f. & cert. ef. 8-1-94; OHCS 12-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 11-2007, f. & cert. ef. 1-11-07; OHCS 15-2013(Temp), f. & cert. ef. 6-21-13 thru 12-18-13

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Rule Caption: Amends the process for soliciting and administering funding awards for Low-Income Weatherization Assistance Program
Adm. Order No.: OHCS 16-2013(Temp)
Filed with Sec. of State: 6-21-2013
Certified to be Effective: 6-21-13 thru 12-17-13
Notice Publication Date:
Rules Adopted: 813-205-0082, 813-205-0145, 813-205-0150
Rules Amended: 813-205-0000, 813-205-0020, 813-205-0030, 813-205-0040, 813-205-0050, 813-205-0051, 813-205-0052, 813-205-0060, 813-205-0070, 813-205-0080, 813-205-0085, 813-205-0100, 813-205-0110, 813-205-0120, 813-205-0130
Rules Suspended: 813-205-0010, 813-205-0140
Subject: The Low-Income Weatherization Program carries out the Department's role in administering state and federal weatherization assistance programs at the local level. The department has completed a significant reorganization as to how it solicits and administers funding awards for this program as part of the restructure. These rule changes are designed to reflect the significant reorganization of the department.
Rules Coordinator: Sandy McDonnell—(503) 986-2012

813-205-0000
Purpose and Objectives

OAR chapter 813, division 205, is promulgated to carry out the Department's role in administering state and federal weatherization programs. Additional policies and instructions for such programs are outlined in the Low Income Weatherization Assistance Program Manual dated June 21, 2013 (the "LIWP Manual" or "Manual"), incorporated herein by reference. The Manual may be accessed online at the Department's website. Weatherization assistance is provided under programs at the local level as follows:

(1) The Low Income Weatherization Program for Rental Housing, included herein, through developers of affordable rental housing; and

(2) The Low Income Weatherization Assistance Program, including all other low income weatherization assistance, which is provided through a network of service-provider agencies.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 458.505, 757.612
Hist.: OHCS 9-2002(Temp), f. & cert. ef. 6-19-02 thru 12-15-02; OHCS 19-2002, f. & cert. ef. 12-13-02; OHCS 13-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 6-2007, f. & cert. ef. 1-11-07; OHCS 16-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

813-205-0010
Definitions

All terms are used in OAR chapter 813, division 205, as defined in the Act, and as provided in OAR 813-005-0005 and herein. As used in these rules, unless otherwise indicated by the context:

(1) "ACE" means Advisory Committee on Energy.

(2) "Applicant" means project sponsor, developer, borrower or income eligible applicant.

(3) "Client Energy Education" means the activities and instruction designed to help low-income clients make appropriate decisions and lifestyle changes to effectively reduce energy consumption.

(4) "Community Resources Department (CRD) Grant Application" means the biennial planning document approved by the Department that outlines how each Subgrantee Agency determines its community's needs, including what forum is used to solicit input and who participates; summarizes each area's needs, goals and outcome-based objective; and contains a quarterly reporting requirement that lets the Department and the agency determine if benchmarks are being met.

(5) "Consolidated Funding Cycle (CFC)" means any activities, reviews, applications and associated funding in regard to the open, competitive process to distribute grant and tax credit funds for affordable, multi-unit, low-income rental housing development.

(6) "Department" means the Housing and Community Services Department of the State of Oregon.

(7) "Director" means the Director of the Department of Housing and Community Services.

(8) "Disabled" means a physical or mental impairment as outlined in Section 504 of the Rehabilitation Act of 1973, as amended.

(9) "DOE" means the state Department of Energy.

(10) "ECHO" means Energy Conservation Helping Oregonians, enacted by the 1999-2001 Oregon Legislature.

(11) "Elderly" means those Persons 60 years of age and over as applied to the Low Income Weatherization Assistance Program.

(12) "Household" means any individual or group of individuals who are living together as one economic unit and purchase residential energy in common.

(13) "Housing Division" means the roles and duties of the Housing Finance Section, Housing Resources Section, Single-Family Finance Section and Department architects.

(14) "Income" means the total Household receipts before taxes from all sources. Income may be reduced by deductions allowed by the Department. Income does not mean assets or funds over which the applicant has no control.

(15) "LIEAP" is Oregon's Low Income Energy Assistance Program funded through the U.S. Department of Health and Human Services (HHS). Federally it is identified as LIHEAP, which refers to the Low Income Home Energy Assistance Program.

(16) "Low-Income" for the purposes of this Rule, means a household or person whose annual gross annual income is at or below 60 percent of an area's median income.

(17) "Low-Income Weatherization Assistance Program" means an energy efficiency update-program available to households whose total household income is at or below 60% of statewide median income. Energy efficient improvements may include shell measures, base-load, health & safety, minor repair and education.

(18) "Low-Income Weatherization Program" means funding program administered by the Housing Finance and Housing Resources Sections awarded to projects for weatherization and energy conservation activities in new construction or rehabilitation of low-income affordable rental housing projects as further described in OAR 813-205-0090 through 813-205-0140.

(19) "Multi-Family Building" means any residential building containing five (5) or more separate living quarters. This applies to Low-Income Weatherization Assistance and CRD only.

(20) "ODOE" means Oregon Department of Energy.

(21) "Oregon State Plan" means the U.S. Department of Energy (DOE) State Plan and/or the U.S. HHS Low-Income Energy Assistance Program (LIEAP) State Plan.

(22) "PVE" means Petroleum Violation Escrow Fund, a funding source resulting from the U.S. Court's decision on oil company overcharges, used in low-income weatherization projects throughout the State of Oregon, based on available funding.

(23) "Recipient" means successful applicant awarded project funding via a CFC funding cycle.

(24) "Special Population Agency" means an organization formed to serve the unique needs of an identified segment of the population.

(25) "Sponsor" means principle lead recipient, for affordable housing, on behalf of a non-profit or for profit entity applying for project funding for new construction or rehabilitation of existing projects in need of funding.

(26) "State Housing Council" means an OHCS policymaking board, appointed by the Governor of the State of Oregon.

(27) "Statewide Median Income" means the "median" family income in the state determined by the Department. In determining median family income in the state, the Department may, in its discretion, use the official standard established by the U.S. Department of HHS or the U.S. Department of Housing and Urban Development, adjusted for family size.

(28) "Subgrantee Agency" means a local agency or organization with whom the Department has contracted to administer Program activities and services at the local level.

(29) "T&TA Activities" means training and technical assistance activities designed to maximize energy savings, minimize production costs, improve program management, and/or reduce the potential for waste, fraud and abuse.

Stat. Auth.: ORS 458.505 - 458.545
Stats. Implemented: ORS 458.505 - 458.515
Hist.: OHCS 9-2002(Temp), f. & cert. ef. 6-19-02 thru 12-15-02; OHCS 19-2002, f. & cert. ef. 12-13-02; OHCS 13-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 6-2007, f. & cert. ef. 1-11-07; Suspended by OHCS 16-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

813-205-0020
Funding Application; Administration

(1) An agency must submit biennially the funding application required by OAR 813-205-0060 for the Low Income Weatherization

Assistance Program. Funding under the program may come from a grant or other sources. The application must include a work plan that:

(a) Outlines the manner in which the agency determines its needs;

(b) Describes the forum the agency uses to solicit input and who participates;

(c) Summarizes the needs of the agency's service area and the goals and outcome-based objectives of the agency;

(d) Requires quarterly reporting; and

(e) Such other information as the Department may require.

(2) An agency providing services under the program may be a community action agency, a limited purpose organization, an area agency on aging, an organization formed to serve the specific needs of an identified segment of the population or any other organization approved by the Department for the purpose.

(3) An agency under this section must follow the procedures in the applicable Oregon State Plan developed as a requirement of federal funding, except when specific rules relating to a particular grant to the agency may override the applicable Oregon State Plan. The specific rules relating to a particular grant may include, but are not limited to identification of potential applicants, certification of eligibility and provision of weatherization services to eligible dwelling units within the service area of the agency.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 458.505, 757.612
Hist.: OHCS 9-2002(Temp), f. & cert. ef. 6-19-02 thru 12-15-02; OHCS 19-2002, f. & cert. ef. 12-13-02; OHCS 13-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 6-2007, f. & cert. ef. 1-11-07; OHCS 16-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

813-205-0030
Eligible Applicants

(1) A household is eligible to receive assistance under the Low Income Weatherization Assistance Program if the Department determines the household meets all requirements of the applicable Oregon State Plan not obviated by specific grant rules, including but not limited to household income guidelines.

(2) A household is eligible for assistance under the program regardless of whether the household rents or owns its dwelling. Households in similar circumstances must receive similar benefits.

(3) An agency may not use a person's race, color, national origin or sex as a basis for excluding the person from participating in any activity funded in whole or in part with funds made available from the program, for denying the benefits of any such activity or for subjecting the person to discrimination under any activity. An agency must provide assurances to the Department that the agency complies with any prohibition against discrimination on the basis of age under the Age Discrimination Act of 1975 or with respect to an otherwise qualified handicapped individual as provided in Section 504 of the Rehabilitation Act of 1973.

(4) An agency shall create a waiting list of applicants for receiving program weatherization services and shall establish criteria for determining applicant priority on the waiting list. The agency shall maintain the criteria in its files and shall file the criteria with the Department. An agency must use the priority consistently for all applicants except with respect to any Department-sanctioned special project in which the agency is involved. An agency's criteria may include factors that encourage leveraging additional resources or the potential for energy savings. An agency shall give priority to at least the following:

(a) Individuals who are 60 years of age or older;

(b) Individuals who are disabled; and

(c) Households with children of less than six years of age.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 458.505, 757.612
Hist.: OHCS 9-2002(Temp), f. & cert. ef. 6-19-02 thru 12-15-02; OHCS 19-2002, f. & cert. ef. 12-13-02; OHCS 13-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 6-2007, f. & cert. ef. 1-11-07; OHCS 16-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

813-205-0040
Eligible Services

(1) An agency may provide any one of the following services to an eligible applicant under the Low Income Weatherization Assistance Program:

(a) Any general weatherization measure including, but not limited to general heat waste, insulation, heating system repair and replacement, health and safety inspections and improvements, baseload measures, and educational activities and instruction designed to help low income clients make appropriate decisions and lifestyle changes to effectively reduce energy consumption; and

(b) Any measure that is necessary for effective energy savings performance or preservation of weatherization materials.

(2) Except as otherwise specified by the grantor of funds, the Department may allocate no more than five percent of the program's funds for training and technical assistance activities designed to maintain or increase the efficiency, quality and effectiveness of the program at all levels. Training and technical assistance activities may include, but are not limited to those maximizing energy savings, minimizing production costs, improving program management and reducing the potential for waste, fraud and abuse.

(3) An agency may request technical assistance from the Department to improve the agency's management of program activities and increase the effectiveness of its customer service efforts.

(4) A property owner may sell multifamily business energy tax credits generated through the weatherization of investment property or assign said tax credits to the agency that provided the weatherization services.

(5) An agency may weatherize a building with five or more separate living quarters that pay space rent if 66 percent of the living quarters are occupied by income eligible households.

(6) An agency may weatherize a building with five or more separate living quarters if the owner pays 10 percent or more of the total cost of weatherization and if at least 50 percent of the occupants meet income eligibility guidelines. An agency may not use the 50 percent income eligibility exception unless the agency first submits a work plan to the Department and has received the Department's approval.

(7) An agency shall practice lead safe work practices on each dwelling constructed prior to 1978 unless the agency can prove to the Department's satisfaction that a lead hazard does not exist.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 458.505 757.612
Hist.: OHCS 9-2002(Temp), f. & cert. ef. 6-19-02 thru 12-15-02; OHCS 19-2002, f. & cert. ef. 12-13-02; OHCS 13-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 6-2007, f. & cert. ef. 1-11-07; OHCS 16-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

813-205-0050
Allocation of Federal Funds

(1) The Department may set aside up to three percent of the federal funds from the Low Income Weatherization Assistance Program funds for Native American populations to either provide direct funding to Native American tribes or allocate funds to an agency with recognized Native American populations.

(2) If any such funds remain after Department expenditures for administrative costs, for set-aside purposes or for training and technical assistance activities designed to maximize energy savings, minimize production costs, improve program management or reduce the potential for waste, fraud or abuse, the remaining funds are subject to allocation to agencies by the Department on the basis of an allocation formula that is in the applicable Oregon State Plan and is based on the percentage of poverty low-income households in a service area and on heating degree days.

(3) The Department may move grant funds from an agency that is not spending allocated funds in a timely manner to an agency that has expended its funds before the end of the grant period. An agency is subject to at least annual Department reviews of the agency's spending patterns for the purpose of reallocating funds.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 458.505 767.612
Hist.: OHCS 9-2002(Temp), f. & cert. ef. 6-19-02 thru 12-15-02; OHCS 19-2002, f. & cert. ef. 12-13-02; OHCS 13-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 6-2007, f. & cert. ef. 1-11-07; OHCS 16-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

813-205-0051
Allocation of State Funds from Energy Conservation Helping Oregonians (ECHO)

(1) State funds in the Low Income Weatherization Assistance Program that are received from the Energy Conservation Helping Oregonians (ECHO) Program are subject to allocation by the Department on the basis of the number of residential meters of a participating utility within the service territory of an agency as a percentage of the utility's total residential meters statewide.

(2) On July 1of each year, each utility shall furnish the Department a residential meter count for each county, for use in adjusting allocations to agencies participating in weatherization activities.

(3) This rule applies only to households that receive electric service from Pacific Power or Portland General Electric. A household that uses hard wired electrical systems as its primary heat source is eligible to receive weatherization, baseload and educational services only.

(4) Funds from the Bonneville Power Administration may not be used in conjunction with the state funds to which this rule applies.

(5) The Department may move grant funds from an agency that is not spending allocated funds in a timely manner to an agency that expended its

funds before the end of the grant period. An agency is subject to at least annual Department reviews of the agency's spending patterns for the purpose of reallocating funds.

(6) Funds under this rule are subject to reallocation for special projects and pilots to programs other than those operated by agencies, once the funding needs of all agencies have been met.

(7) An agency shall follow the approved ECHO Weatherization Guidelines when delivering services under this rule. The Advisory Committee on Energy shall review the guidelines annually and amend them as appropriate.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 458.505 767.612
Hist.: OHCS 19-2002, f. & cert. ef. 12-13-02; OHCS 13-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 6-2007, f. & cert. ef. 1-11-07; OHCS 16-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

813-205-0052
Allocation of Other Funds

The Department shall, at its reasonable discretion, allocate funds in the Low Income Weatherization Assistance Program that were received from legal settlements or otherwise in order to improve and address the energy needs of low income households.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 458.505 767.612
Hist.: OHCS 13-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 6-2007, f. & cert. ef. 1-11-07; OHCS 16-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

813-205-0060
Authorization of Weatherization Projects

(1) An agency may not provide weatherization assistance under the Low Income Weatherization Assistance Program unless the owner of a dwelling first gives written permission to the agency. The permission must include the following information:

(a) The street address of the dwelling;

(b) The name of the owner or of the eligible tenant, whichever is applicable; and

(c) A description of the specific work to be done.

(2) If the dwelling to be weatherized is a rental unit, the agency shall:

(a) Ensure that the unit will not be weatherized unless the agency has first obtained the written permission of the owner of the individual unit or multiunit dwelling of which the unit is a part; and

(b) Establish procedures and obtain the Department's approval thereof, to ensure that:

(A) The residence considered for weatherization is not currently for sale by the owner of the property or designated for acquisition, clearance or foreclosure under a federal, state or local program;

(B) The benefits of weatherization assistance accrue primarily to the low-income resident renting the unit;

(C) The rent of the unit will not be raised as a result of the weatherization assistance;

(D) No undue or excessive increase in the value of the unit will occur as a result of the weatherization assistance and that, if the multiunit dwelling of which the unit is a part is sold within one year after the unit is weatherized, the agency may require the seller to reimburse the agency for the actual cost of weatherization on a prorated basis, determined according to the energy cost buyback of measures; and

(E) Weatherization assistance will not be provided for a unit for which the tenant pays the cost of energy as part of their rent, unless the landlord agrees to reduce rent to account for the reduction in fuel costs associated with the weatherization, or unless health or safety reasons justify weatherization.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 458.505 767.612
Hist.: OHCS 9-2002(Temp), f. & cert. ef. 6-19-02 thru 12-15-02; OHCS 13-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 6-2007, f. & cert. ef. 1-11-07; OHCS 16-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

813-205-0070
Required Authorization, Audits and Fiscal Controls

The following provisions apply to an agency that receives funding from the Department under the Low Income Weatherization Assistance Program:

(1) An agency may not purchase a vehicle or equipment with grant funds, regardless of the cost of the vehicle or equipment, or purchase or lease one or more acquisitions when the cost of the purchase or lease exceeds $5,000, unless the agency first receives authorization from the Department.

(2) An agency shall enter all program applicant and job cost information into a Department-approved data system.

(3) An agency shall provide the following reports to the Department, according to form and substance requirements of the Department, as follows:

(a) Not later than the 20th day after the end of each calendar quarter, a program report that describes the progress made by an agency toward the program's objectives, and all administrative and program expenditures.

(b) Not later than the 90th day after the close of the agency's fiscal year, an annual audit of the weatherization funds that is conducted by a certified public accountant.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 458.505, 757.612
Hist.: OHCS 9-2002(Temp), f. & cert. ef. 6-19-02 thru 12-15-02; OHCS 19-2002, f. & cert. ef. 12-13-02; OHCS 13-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 6-2007, f. & cert. ef. 1-11-07; OHCS 16-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

813-205-0080
Monitoring

(1) An agency's annual audit is subject to monitoring by the Department under OAR 813-061-0070 so that the Department, inter alia, may verify information received in the quarterly reports and so that questions raised by the Department, the agency or the auditor may be answered.

(2) An agency's quarterly reports and program data entered into the statewide database as specified by the Department are subject to monitoring by the Department so that the Department may determine the agency's compliance with program requirements, monitor spending patterns and chart changes in the program. An agency is subject to an on-site review by the Department if the Department determines that irregularities or questions raised by the Department's in-house review are sufficient to warrant the onsite review.

(3) An agency and the owner of any project approved for program assistance is subject to such monitoring and on-site reviews by the Department as it may require. The Department may examine matters including, but not limited to the following in its off-site and on-site reviews and auditing functions:

(a) Financial records;

(b) The inventory system;

(c) Client files;

(d) Work completed;

(e) Agency post-installation inspection;

(f) Agency review; and

(g) Records of training and technical assistance provided by the agency.

(4) An agency also is subject to evaluations by the Department of the agency's performance under the program, including but not limited to the level of service provided, ease of access to applicants, error rate and compatibility with other community service programs. These evaluation functions may be performed separately or in conjunction with other auditing and review functions by the Department.

(5) An agency shall cooperate fully with all Department audit, review and evaluation requests and activities.

(6) An agency and the owner of a project receiving program assistance shall retain related financial records, supporting documents and all other pertinent records for six years after the receipt of assistance or after any litigation or audit claim is resolved, whichever is later.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 458.505, 757.612
Hist.: OHCS 9-2002(Temp), f. & cert. ef. 6-19-02 thru 12-15-02; OHCS 13-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 6-2007, f. & cert. ef. 1-11-07; OHCS 16-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

813-205-0082
Charges; Transfers

(1) The Department may charge for reasonably anticipated costs of program administration including, but not limited to monitoring costs and transfer review costs.

(2) The owner of a project approved for assistance under this program shall not transfer any assistance, any interest in the project or any interest in itself without the prior written approval of the Department. Unapproved transfers are voidable by the Department.

(3) The Department may require payment of a transfer review charge:

(a) From an owner of a project approved for assistance under this program that requests a transfer; or

(b) From such a former owner or the transferee with respect to an unapproved transfer.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 458.505, 757.612
Hist.: OHCS 16-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

813-205-0085
Program Administration, Authority

OAR 813-205-0085 to 813-205-0150 address protocols, standards and requirements with respect to the Low Income Weatherization Program for Rental Housing. Additional policies and instructions for this program are outlined in the LIWP Manual. The Department allocates funds for this program through developers of affordable rental housing. Such funds are directed to the Department under ORS 757.612(7) to carry out weatherization needs of low income households pursuant to the Department's authority to provide crisis assistance with funding available from the Energy Crisis Trust Fund under ORS 758.510 for antipoverty programs.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 458.505, 757.612
Hist.: OHCS 13-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 6-2007, f. & cert. ef. 1-11-07; OHCS 16-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

813-205-0100
Eligible Applicants

(1) Any of the following may apply to the Department for approval of a project under the Low Income Weatherization Program for Rental Housing:

(a) A for-profit business,

(b) A local government entity including but not limited to a city, county or housing authority;

(c) A not-for-profit organization, including but not limited to a not-for-profit community organization, a regional or statewide not-for-profit entity, a private individual or a not-for-profit corporation.

(2) An applicant under subsection (1) of this section or a principal representative of the applicant as approved by the Department must enter into a financial assistance agreement with the Department, satisfactory to the Department, and record such agreement against the real property of the project so as to create restrictive covenants running with such real property that assure continuing compliance with all habitability and affordability requirements of the program.

Stat. Auth.: ORS 46.555
Stats. Implemented: ORS 458.505, 757.612
Hist.: OHCS 13-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 6-2007, f. & cert. ef. 1-11-07; OHCS 16-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

813-205-0110
Eligible Projects

The provisions of this section, in addition to the requirements of the Department's bond programs, the open, competitive process for distributing grant and tax credit funds for affordable multi-unit low income rental housing development and other application processes and charges, apply to all projects under the Low Income Weatherization Program for Rental Housing as follows:

(1) State funding from the Energy Conservation Helping Oregonians Program is limited to projects located in the PacifiCorp and Portland General Electric service areas. Projects that use hard wired electrical systems as their primary heat source are eligible to receive funding from the Act for weatherization, and baseload services. Projects in PaciCorp and Portland General Electric service areas that heat with other fuels may receive baseload measures only.

(2) Applications for weatherization funding for projects located outside PacifiCorp and Portland General Electric service areas are subject to acceptance by the Department only when funds from sources other than PacifiCorp or Portland General Electric funds are available.

(3) The following projects are eligible under the program:

(a) New construction projects which specify higher than code minimums on insulation, windows, appliances and lighting; and

(b) Acquisition/rehabilitation projects that specify upgrades from original levels of insulation, windows, appliances and lighting.

(4) Households that are low-income are eligible for the program. A household is low income for the purpose of the program if the household income is at or below 60 percent of an area's median income. At least one-half of the units in the project must be rented to households whose income is at or below 60 percent of the area median income as defined by the U.S. Department of Housing and Urban Development (HUD).

(5) The project must remain affordable for a minimum of 10 years, unless superseded by other department resource requirements.

(6) The Department may require more extensive or enduring affordability requirements than those required in subsections (4) and (5) of this section.

(7) An applicant may be subject to prevailing wage requirements with the use of public funds under the Low-Income Weatherization Program for Rental Housing. An applicant is advised to consider contacting the applicant's legal representative or the Oregon Bureau of Labor and Industries for the requirements of the state program.

Stat. Auth.: ORS 46.555
Stats. Implemented: ORS 458.505, 757.612
Hist.: OHCS 13-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 6-2007, f. & cert. ef. 1-11-07; OHCS 16-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

813-205-0120
Eligible Activities

(1) Under the Low-Income Weatherization Program for Rental Housing, an eligible applicant may provide services and applications including, but not limited to one or more of the following:

(a) A general weatherization measure that includes, but is not limited to general heat waste, insulation, heating and cooling system repair, replacement or installation, health and safety improvements, baseload measures, alternative energy applications, and various energy efficient technology; and

(b) Any repair measure that the Department determines appropriate for effective energy savings performance or preservation of energy efficient applications.

(2) To be eligible under this section, an activity must demonstrate measurable cost-effective energy conservation to the Department's satisfaction. An energy-efficient application for the program must show first year savings based on a pre-determined number of kilowatts, therms or other units of power measurements for each conservation dollar invested.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 458.505, 757.612
Hist.: OHCS 13-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 6-2007, f. & cert. ef. 1-11-07; OHCS 16-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

813-205-0130
Fund Uses

(1) The Department may award funds under the Low-Income Weatherization Program for Housing as a grant or a loan, including as requested by the applicant or sponsor of a project.

(2) If the amount of a grant or loan proposal meets or exceeds the threshold amount established in OAR 813-001-0007(1) for review by the State Housing Council for a rental housing development, the Department may award the grant or loan on an as-needed basis, when the maximum power savings can be demonstrated and if adequate resources are available. An award under this section is subject to review by the State Housing Council for approval or disapproval under OAR 813-001-0007(1).

(3) An applicant may use not more than ten percent of funds available from the state Energy Conservation Helping Oregonians Program and from Low-Income Weatherization Program award for each project to make general repairs if the Department determines that adequate resources are available.

Stat. Auth.: ORS 456.515 - 456.725, 458.505 - 458.545
Stats. Implemented: ORS 458.505 - 458.515
Hist.: OHCS 13-2006(Temp), f. & cert. ef. 8-4-06 thru 1-30-07; OHCS 6-2007, f. & cert. ef. 1-11-07; OHCS 16-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

813-205-0140
Waiver

The Director may waive or modify any requirements of these Program rules, unless such waiver or modification would violate applicable federal or state statutes or regulations.

Stat. Auth.: ORS 456.555
Stats. Implemented: ORS 456.555
Hist.: OHCS 9-2002(Temp), f. & cert. ef. 6-19-02 thru 12-15-02; OHCS 19-2002, f. & cert. ef. 12-13-02; OHCS 15-2006, f. & cert. ef. 8-4-06, Renumbered from 813-205-0090; Suspended by OHCS 16-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

813-205-0145
General Administrative and Monitoring Requirements

(1) An applicant or owner of a project approved for program assistance shall timely submit to the Department such information as the Department may require for the purpose, inter alia, of compliance monitoring by same.

(2) An applicant or owner of a project approved for program assistance is subject to reviews and field inspections that the Department determines to be necessary or appropriate including, but not limited to ensuring the applicant's and project owner's compliance with program requirements. The applicant and project owner shall cooperate fully with all reviews and field inspections, timely comply with any resulting correction directives, and make all records available for inspection and copying.

(3) A recipient of program assistance or owner of a project receiving such assistance shall retain related financial records, supporting documents and all other pertinent records for six years after the receipt of assistance or after any litigation or audit claim is resolved, whichever is later.

Stat. Auth.: ORS 456.515 - 456.725, 458.505 - 458.545
Stats. Implemented: ORS 458.505 - 458.515
Hist.: OHCS 16-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

813-205-0150
Charges; Transfers

The Department may charge for the reasonably anticipated costs of its administration of the Low-Income Weatherization Program for Rental Housing. Such charges may include, but are not limited to the following:

(1) A non-refundable application charge, from an applicant under OAR 813-205-0100.

(2) A supplemental application charge, from an owner of a project approved by the Department under the program who requests additional resources for a project that is funded by the Department.

(3) A transfer application charge from an owner of an approved project who requests the Department's approval of a change in project ownership, or from the transferee of ownership.

(4) A transfer review charge from an owner of an approved project who effects a change in project ownership without prior written Department approval, or from the transferee of ownership.

Stat. Auth.: 456.555
Stats. Implemented: ORS 458.505, 458.510, 757.612
Hist.: OHCS 16-2013(Temp), f. & cert. ef. 6-21-13 thru 12-17-13

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Oregon Liquor Control Commission
Chapter 845

Rule Caption: Temporary rules to restore technically deficient rulemaking from 2012 while permanent rulemaking is in progress.
Adm. Order No.: OLCC 4-2013(Temp)
Filed with Sec. of State: 7-12-2013
Certified to be Effective: 7-15-13 thru 1-11-14
Notice Publication Date:
Rules Amended: 845-006-0392, 845-006-0396
Subject: These rules set forth the requirements under which a person may ship malt beverages, wine and/or cider directly to a resident of Oregon.

On April 5, 2012, the Commission voted to amend OAR 845-006-0392 and 845-006-0396, effective May 1, 2012. Shortly thereafter, in accordance with filing procedures in place at that time, hard copies of the adopted amendments were sent by shuttle delivery service to both the Secretary of State and to Legislative Counsel. Unfortunately, on this particular occasion, delivery was made to Legislative Counsel before it was made to the Secretary of State; this is a violation of ORS 183.715. Consequently, under ORS 183.335(11)(b), the amendments adopted in 2012 are invalid.

On July 12, 2013, the Commission adopted temporary rules (effective July 15, 2013) without prior notice or hearing to temporarily restore the invalidated 2012 amendments.

Because permanent rulemaking was initiated prior to the discovery of the technical defects that necessitated temporary rulemaking, the Commission will reschedule and re-notice the previously scheduled Public Hearing to address these new circumstances.

The temporary rules will remain in effect until permanent rules are adopted or until the temporary rules expire on January 11, 2014; whichever is first to occur.
Rules Coordinator: Annabelle Henry—(503) 872-5004

845-006-0392
Requirements for Direct Shipment of Wine and Cider to a Resident of Oregon

(1) A person may sell and ship wine or cider to a resident of Oregon only if the person holds:

(a) A valid Direct Shipper Permit and holds a license issued by this state or another state that authorizes the person to hold a Direct Shipper Permit; or

(b) An off-premises sales license issued by the Commission.

(2) A person holding a Direct Shipper Permit must ship not more than a total of two cases of wine or cider containing not more than nine liters per case per month to a resident of Oregon who is at least 21 years of age.

(3) A person holding a Direct Shipper Permit or an off-premises sales license must retain a record for a minimum of eighteen months of the amount of alcohol contained in the shipment to the resident.

(4) A person holding a Direct Shipper Permit or an off-premises sales license must ship:

(a) Only wine or cider and only in manufacturer-sealed containers;

(b) Only to a resident of Oregon who is at least 21 years of age and only if the wine or cider is for personal use and not for the purpose of resale;

(c) Only for delivery to a resident who is not visibly intoxicated at the time of receiving the alcohol;

(d) The product in a container that is conspicuously labeled with the words "Contains alcohol: signature of person age 21 years or older required for delivery" or similar language approved by the Commission;

(e) Only pursuant to an order for the wine or cider that is received by the permit holder or licensee prior to shipment of the alcohol;

(f) Only for next-day delivery, unless the permit holder or licensee has been approved for same-day delivery; and

(g) Only to a home or business where the home or business has a permanent street address.

(5) If the permit holder or licensee ships via a for-hire carrier, the permit holder and licensee must use a for-hire carrier with a plan approved by the Commission under OAR 845-005-0424 and must comply with sections (2), (3), and (4) of this rule, as applicable.

(6) If the permit holder or licensee does not use a for-hire carrier, in addition to complying with sections (2), (3), and (4) of this rule, as applicable, the person making the delivery of the wine or cider must:

(a) Be age 18 or over;

(b) Verify by inspecting government-issued photo identification that the person receiving the alcohol is at least 21 years of age;

(c) Determine that the person receiving the alcohol is not visibly intoxicated; and

(d) Collect information that must be retained by the permit holder or licensee for a minimum of eighteen months from the date of delivery of the alcohol to the resident. The information may be collected and retained electronically (if the permit holder or licensee so chooses) and must include:

(A) The date and time the alcohol was delivered to the resident;

(B) The name or information that can be used to determine the name of the person delivering the alcohol to the resident; and

(C) The name, signature, and delivery address of the person receiving the alcohol.

(7) Same-day delivery for a permit holder. If a permit holder has also obtained approval to make same-day delivery of wine or cider, in addition to complying with sections (2), (3), (4), and either (5) or (6) of this rule, the permit holder must receive the order from the resident no later than 4:00 pm on the day the order is delivered, ensure that the wine and cider is delivered before 9:00 pm, and deliver not more than a total of two cases of wine or cider containing not more than nine liters per case per day to a resident of Oregon (and must also follow section (2) of this rule).

(8) Same-day delivery for a licensee. If a licensee has also obtained approval to make same-day delivery of wine or cider, in addition to complying with sections (3), (4), and either (5) or (6) of this rule, the licensee must:

(a) Receive the order from the resident no later than 4:00 pm on the day the order is delivered, ensure that the wine and cider is delivered before 9:00 pm, and deliver not more than a total of two cases of wine or cider containing not more than nine liters per case per day per Oregon residence; or

(b) Receive the order from the resident no later than 4:00 pm on the day the order is delivered, ensure that the wine and cider is delivered before 9:00 pm, and may deliver an unlimited amount of wine or cider if the alcohol accounts for no more than 25 percent of the retail cost of the order (at least 75 percent of the retail cost of the order must be items other than alcohol); or

(c) Receive the order from the resident no later than 9:00 am on the day the order is delivered, ensure that the wine and cider is delivered before 9:00 pm, and may deliver an unlimited amount of wine or cider; or

(d) Receive the order from the resident no later than 7:00 pm on the day the order is delivered, ensure that the wine and cider is delivered before 9:00 pm, and deliver not more than a total of two bottles of wine or cider containing not more than 750 milliliters per bottle per day per Oregon residence.

(9) A permit holder must:

(a) Allow the Commission to audit the permit holder's records of wine and cider shipments to Oregon residents upon request and shall make those records available to the Commission in Oregon no later than 60 days after the Commission mails the notice;

(b) Report to the Commission all shipments of wine or cider made to a resident of Oregon under the permit as required by ORS Chapter 473. The report must be made in a form prescribed by the Commission; and

(c) Timely pay to the Commission all taxes imposed under ORS Chapter 473 on wine and cider sold and shipped directly to a resident of Oregon under the permit. For the purpose of the privilege tax imposed under ORS Chapter 473, all wine or cider sold and shipped pursuant to a direct shipper permit is sold in this state. The permit holder, not the purchaser, is responsible for the tax.

(10) If the permit holder is located in a state outside of Oregon, it consents to the jurisdiction of the Commission and the courts of this state for the purpose of enforcing the provisions of this rule and any related laws or rules.

(11) A violation of section (9) of this rule is a Category IV violation. A violation of any other section of this rule is a Category III violation. In lieu of a criminal citation, the Commission may assess an administrative penalty for shipping wine or cider without a valid Direct Shipper Permit in violation of section (1) of this rule against any Oregon license held by the shipper, including a Certificate of Approval issued pursuant to ORS 471.289.

Stat. Auth.: ORS 471, 471.030, 471.040, 471.186 & 471.730(1) & (5)
Stats. Implemented: ORS 471.186, 471.282 & 473
Hist.: OLCC 23-2007(Temp), f. 12-14-07, cert. ef. 1-1-08 thru 6-28-08; OLCC 6-2008(Temp), f. & cert. ef. 4-18-08 thru 6-28-08; OLCC 8-2008, f. 6-12-08, cert. ef. 6-29-08; OLCC 4-2012, f. 4-10-12, cert. ef. 5-1-12; OLCC 4-2013(Temp), f. 7-12-13, cert. ef. 7-15-13 thru 1-11-14

845-006-0396
Requirements for Same-Day and Next-Day Retail Delivery of Malt Beverages to a Resident of Oregon

This rule sets the requirements for same-day and next-day delivery of malt beverages to a resident of Oregon. A licensee must be approved by the Commission under OAR 845-005-0420 in order to provide same-day delivery of malt beverages.

(1) A licensee qualified to make same-day or next-day delivery of malt beverages under OAR 845-005-0420 must ship:

(a) Only malt beverages and only in a manufacturer-sealed container. A container must not hold more than two and one-quarter gallons;

(b) Only to a resident of Oregon who is at least 21 years of age and only if the malt beverage is for personal use and not for the purpose of resale;

(c) Only for delivery to a resident who is not visibly intoxicated at the time of receiving the alcohol;

(d) The malt beverage in a package that is conspicuously labeled with the words "Contains alcohol: signature of person age 21 years or older required for delivery" or similar language approved by the Commission;

(e) Only pursuant to an order for the malt beverage that is received by the licensee prior to shipment of the alcohol;

(f) Only for next-day delivery unless the licensee has been approved for same-day delivery by the Commission; and

(g) Only to a home or business where the home or business has a permanent street address.

(2) A licensee must retain a record for a minimum of eighteen months of the amount of alcohol contained in the shipment to the resident.

(3) If the licensee ships via a for-hire carrier, in addition to complying with sections (1) and (2) of this rule, the licensee must use a for-hire carrier with a plan approved by the Commission under OAR 845-005-0424.

(4) If the licensee does not use a for-hire carrier, in addition to complying with sections (1) and (2) of this rule, the person delivering the malt beverage must:

(a) Be age 18 or over;

(b) Verify by inspecting government-issued photo identification that the person receiving the alcohol is at least 21 years of age;

(c) Determine that the person receiving the alcohol is not visibly intoxicated; and

(d) Collect information that must be retained by the licensee for a minimum of eighteen months from the date of delivery of the alcohol to the resident. The information may be collected and retained electronically (if the licensee so chooses) and must include:

(A) The date and time the alcohol was delivered to the resident;

(B) The name or information which can be used to determine the name of the person delivering the alcohol to the resident; and

(C) The name, signature, and delivery address of the person receiving the alcohol.

(5) Same-day delivery. If the licensee is approved to make same-day delivery of malt beverages, in addition to complying with sections (1), (2), and either (3) or (4) of this rule, the licensee must:

(a) Receive the order from the resident no later than 4:00 pm on the day the order is delivered, ensure that the malt beverage is delivered before 9:00 pm, and deliver not more than a total of five gallons of malt beverage per day per Oregon residence; or

(b) Receive the order from the resident no later than 4:00 pm on the day the order is delivered, ensure that the malt beverage is delivered before 9:00 pm, and may deliver an unlimited amount of malt beverage if the alcohol accounts for no more than 25 percent of the retail cost of the order (at least 75 percent of the retail cost of the order must be items other than alcohol); or

(c) Receive the order from the resident no later than 9:00 am on the day the order is delivered, ensure that the malt beverage is delivered before 9:00 pm, and may deliver an unlimited amount of malt beverage; or

(d) Receive the order from the resident no later than 7:00 pm on the day the order is delivered, ensure that the malt beverage is delivered before 9:00 pm, and deliver not more than a total of 1.25 gallons (approx. two 6-packs) of malt beverage per day per Oregon residence.

(6) Sanction. A violation of any section of this rule is a Category III violation.

Stat. Auth.: ORS 471, 471.030, 471.040, 471.730(1) & (5)
Stats. Implemented: ORS 471.305
Hist.: OLCC 19-2000, f. 12-6-00, cert. ef. 1-1-01; OLCC 7-2003(Temp), f. & cert. ef. 5-20-03 thru 11-16-03; OLCC 12-2003, f. 9-23-03, cert. ef. 11-1-03; OLCC 23-2007(Temp), f. 12-14-07, cert. ef. 1-1-08 thru 6-28-08; OLCC 6-2008(Temp), f. & cert. ef. 4-18-08 thru 6-28-08; OLCC 8-2008, f. 6-12-08, cert. ef. 6-29-08; OLCC 4-2012, f. 4-10-12, cert. ef. 5-1-12; OLCC 4-2013(Temp), f. 7-12-13, cert. ef. 7-15-13 thru 1-11-14

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Rule Caption: Temporary rule to restore technically deficient rulemaking from 2012 while permanent rulemaking is in progress.
Adm. Order No.: OLCC 5-2013(Temp)
Filed with Sec. of State: 7-12-2013
Certified to be Effective: 7-15-13 thru 1-11-14
Notice Publication Date:
Rules Amended: 845-006-0335
Subject: This rule describes a licensee's and a permittee's duty to prevent minors from purchasing or consuming alcohol on the licensed premises and from entering areas prohibited to minors.

On April 5, 2012, the Commission voted to amend OAR 845-006-0335, effective May 1, 2012. Shortly thereafter, in accordance with filing procedures in place at that time, hard copies of the adopted amendments were sent by shuttle delivery service to both the Secretary of State and to Legislative Counsel. Unfortunately, on this particular occasion, delivery was made to Legislative Counsel before it was made to the Secretary of State; this is a violation of ORS 183.715. Consequently, under ORS 183.335(11)(b), the amendments adopted in 2012 are invalid.

On July 12, 2013, the Commission adopted temporary rules (effective July 15, 2013) without prior notice or hearing to temporarily restore the invalidated 2012 amendments. On the same day, the Commission initiated permanent rulemaking to correct the technical defect that has invalidated the 2012 amendments.

The temporary rule will remain in effect until a permanent rule is adopted or until the temporary rule expires on January 11, 2014; whichever is first to occur.
Rules Coordinator: Annabelle Henry—(503) 872-5004

845-006-0335
Age Verification; Minors on Licensed Premises

(1) Age Verification:

(a) ORS 471.130 requires a licensee or permittee to verify the age of a person who wants to buy or be served alcoholic beverages when there is "any reasonable doubt" that the person is at least 21 years old. The Commission requires a licensee or permittee to verify the age of anyone who wants to drink alcoholic beverages, or is in an area prohibited to minors, if there is reasonable doubt that the person is at least 21 years old. "Reasonable doubt" exists if the person appears to be under the age of 26;

(b) Whenever a licensee or permittee verifies age, he/she must verify it as ORS 471.130 requires (statement of age card or the specified items of identification) and must reject any obviously altered document or one which obviously does not identify the person offering it;

(c) Licensees must require all their employees who sell, serve, oversee or control the sale or service of alcoholic beverages to verify age as subsection (a) of this section requires.

(2) Sanctions for Failure to Verify Age:

(a) The Commission will sanction a licensee or permittee who does not verify the age of a person who appears to be under the age of 26 only if the person:

(A) Actually is a minor who buys, is served or drinks an alcoholic beverage at the licensed premises (Category III violation); or

(B) Actually is a minor who is in an area of the licensed premises prohibited to minors (Category IV violation).

(b) If the Commission sanctions a licensee or permittee for one or more of the following violations under this rule: Failure to verify the age of a minor; Allowing a minor to drink; or Allowing a minor in an area prohibited to minors, the Commission will not sanction the licensee or permittee separately under ORS 471.130 or 471.410 (2) for the same conduct. The Commission may charge a licensee or permittee for one or more violations under this rule and also charge violation of one or more of the statutes in the alternative.

(c) Failure to verify age as ORS 471.130 requires or to reject obviously altered or false identification is a Category III violation.

(3) Minors on Premises: General Prohibitions. No licensee, permittee, or licensee's employee will permit a minor:

(a) To drink any alcoholic beverage on licensed premises;

(b) To be on licensed premises or an area of the licensed premises prohibited to minors, except as provided in ORS 471.430, 471.480, 471.482, and this rule. (The assigned minor posting(s) describes where on the premises minors are allowed or prohibited. See OAR 845-006-0340, Minor Postings.)

(4) Minor Employee and Minor Service Permittee:

(a) Whenever minors are prohibited from an entire licensed premises, minor employees and minor service permittees are also prohibited. This applies to a premises with a Number I minor posting and when minors are prohibited from the entire premises under a Number IIIA, IV or VI minor posting.

(b) When minors are allowed in a premises or portion of a premises, minor employees and minor service permittees are permitted in the areas of the premises where minors are allowed. This applies to a premises or area with a Number III posting and to a premises or area with a Number IIIA, IV or VI posting during the times when minors are allowed. The primary duty of minor service permittees must be food service.

(c) If a premises has one or more areas where minors are prohibited and one or more areas where minors are allowed, the following requirements apply. An example is a premises with a Number III posting in the dining room and a Number II posting in the lounge.

(A) Minor employees who are not service permittees may be in areas prohibited to minors only to restock supplies and perform food service related activities such as setting and clearing tables and delivering food. The minor shall not remain in the prohibited area longer than is necessary to perform these duties.

(B) Minor service permittees may perform the duties of minor employees as described in subsection (4)(c)(A) of this rule as well as enter the prohibited areas to order and pick up alcoholic drinks for service in other areas of the premises where minors are allowed.

(5) Minor Vendor or Contractor. A minor, other than a licensee's employee, who has a legitimate business purpose, may be in the area of the licensed premises normally prohibited to minors. (For example, a minor who is a plumber may repair the plumbing in a prohibited area).

(6) Minor Entertainer:

(a) A minor entertainer may perform on licensed premises. If the minor entertainer stays on the premises when not performing, he/she must stay in an area where minors are permitted, such as an area with a Number III posting. If there is no break room, dressing room or patron area where minors are permitted, the licensee may, with prior Commission approval, designate space for minor entertainers in an area of the licensed premises normally prohibited to them. At a minimum, this place must be within the bartender's sight but not at the bar, and there must be no alcoholic beverages in this place. If a minor entertainer is not performing and not in a Commission approved designated area on the licensed premises, then the minor entertainer must be off the licensed premises.

(b) If the minor is under 18 years old, and the licensee proposes to employ that minor to conduct or assist in conducting any public dance, including but not limited to dancing by the child as a public performance, or to assist in or furnish music for public dancing, the licensee and minor must make sure the minor has the written permission of the appropriate juvenile court judge as required by ORS 167.840(2).

(c) If the minor is under 18 years old, and the licensee proposes to employ that minor to perform or entertain on the licensed premises in a capacity other than described in (6)(b) of this rule, before allowing the minor to perform on the licensed premises the licensee must apply for and receive prior written permission from the Administrator of the Oregon Liquor Control Commission, or the Administrator's designee. Application must be made upon a form supplied by the Commission. The Administrator or designee shall grant such permission only if:

(A) The parents or legal guardians of the minor have consented to the child's participation in such activity; and

(B) The Administrator or designee has found that participation in such activity will not be inconsistent with the health, safety and morals of the minor.

(d) Minors under 14 years old must also get a work permit if one is required by the Oregon Bureau of Labor and Industries.

(7) Minor Patron: A minor patron may be in areas of licensed premises normally prohibited to minors in the following circumstances:

(a) If the licensee permits it, a minor may be in the immediate company of his/her spouse or Domestic Partner who is at least 21 years old. "Domestic Partner" means an individual who, along with another individual of the same sex, has received a Certificate of Registered Domestic Partnership pursuant to the Oregon Family Fairness Act. The minor must not buy, possess or drink alcoholic beverages;

(b) A minor may order and eat a meal in a Number IV posted area during the specified meal periods. This meal must at least meet the minimum food service requirements of OAR 845-006-0460.

(8) Sanctions: A violation of subsection (3)(a) of this rule is a Category III violation. A violation of subsection (3)(b) through section (7) of this rule is a Category IV violation.

Stat. Auth.: ORS 471, 471.030, 471.040, 471.430, 471.482 & 471.730
Stats. Implemented: ORS 471.130, 471.410, 471.430, 471.480 & 471.482
Hist.: OLCC 19-2000, f. 12-6-00, cert. ef. 1-1-01; OLCC 12-2002, f. 8-29-02, cert. ef. 1-2-03; OLCC 13-2003(Temp), f. & cert. ef. 9-23-03 thru 3-20-04; OLCC 4-2004, f. & cert. ef. 4-9-04; OLCC 9-2005, f. 11-21-05, cert. ef. 1-1-06; OLCC 9-2008, f. 6-12-08, cert. ef. 7-1-08; OLCC 2-2009, f. 3-17-09, cert. ef. 4-1-09; OLCC 3-2012, f. 4-10-12, cert. ef. 5-1-12; OLCC 5-2013(Temp), f. 7-12-13, cert. ef. 7-15-13 thru 1-11-14

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Oregon Medical Board
Chapter 847

Rule Caption: Memorializes the authority previously delegated to the Executive Director to issue Notices of Civil Penalty
Adm. Order No.: OMB 12-2013(Temp)
Filed with Sec. of State: 7-12-2013
Certified to be Effective: 7-15-13 thru 1-11-14
Notice Publication Date:
Rules Adopted: 847-001-0040
Subject: The temporary rule adoption puts into administrative rule the authority that has been previously delegated by the Board to the Executive Director over approving and signing Notices of Civil Penalty for violation of Board administrative rules.
Rules Coordinator: Nicole Krishnaswami—(971) 673-2667

847-001-0040
Approval of Notices of Civil Penalty

(1) The Executive Director has the authority to issue Notices of Civil Penalty for violations of the Board's administrative rules.

(2) The Executive Director's signature grants approval of the Notice of Civil Penalty, which becomes a public document. As a public document, the Notice of Civil Penalty may be released to the public. However, the civil penalty is not a disciplinary action.

Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.190, 677.205, 677.265
Hist.: OMB 12-2013(Temp), f. 7-12-13, cert. ef. 7-15-13 thru 1-11-14

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Rule Caption: Fee changes as approved
Adm. Order No.: OMB 13-2013(Temp)
Filed with Sec. of State: 7-12-2013
Certified to be Effective: 7-15-13 thru 1-11-14
Notice Publication Date:
Rules Amended: 847-005-0005
Subject: The temporary rule amendment reflects fees approved by the legislature for the 2013-15 biennial budget, including adjusted registration fees, a $100 application fee for a physician to supervise a physician assistant, a one-time surcharge for physician assistants, and a pass-through fee for the actual cost of criminal records checks on applicants or licensees.
Rules Coordinator: Nicole Krishnaswami—(971) 673-2667

847-005-0005
Fees

(1) Licensing Fees:

(a) Doctor of Medicine/Doctor of Osteopathy (MD/DO) Initial License Application — $375.

(b) MD/DO Registration: Active, Administrative Medicine, Inactive, Locum Tenens, Military/Public Health, Telemedicine, Telemonitoring and Teleradiology — $253/year+*.

(c) MD/DO Registration: Emeritus — $50/year.

(d) MD/DO Limited License, SPEX/COMVEX, Visiting Professor, Fellow, Medical Faculty, Postgraduate, Special Application — $185.

(e) MD/DO Application to Supervise a Physician Assistant — $100.

(f) Acupuncture Initial License Application — $245.

(g) Acupuncture Registration: Active, Inactive, Locum Tenens and Military/Public Health —$161/year*.

(h) Acupuncture Registration: Emeritus — $50/year.

(i) Acupuncture Limited License, Special, Visiting Professor, Postgraduate Application — $75.

(j) Physician Assistant Initial License Application — $245.

(k) Physician Assistant Registration: Active, Inactive, Locum Tenens and Military/Public Health — $191/year*.

(l) Physician Assistant Registration: Emeritus — $50/year.

(m) Physician Assistant Surcharge for 2014-2015 registration period — $65.

(n) Physician Assistant Limited License, Special, Postgraduate Application — $75.

(o) Podiatrist Initial Application — $340.

(p) Podiatrist Registration: Active, Administrative Medicine, Inactive, Locum Tenens, Military/Public Health, Telemedicine and Telemonitoring — $243/year*.

(q) Podiatrist Registration: Emeritus — $50/year.

(r) Podiatrist Limited License, Special, Postgraduate Application — $185.

(s) Reactivation Application Fee — $50.

(t) Electronic Prescription Drug Monitoring Program — $25/year**.

(u) Workforce Data Fee — $5/license period***.

(v) Criminal Records Check Fee — $52****.

(w) Oral Specialty or Competency Examination ($1,000 deposit required) — Actual costs.

(2) Delinquent Registration Renewals:

(a) Delinquent MD/DO Registration Renewal — $195.

(b) Delinquent Acupuncture Registration Renewal — $80.

(c) Delinquent Physician Assistant Registration Renewal — $80.

(d) Delinquent Podiatrist Registration Renewal — $195.

(3) Licensee Information Request Charges:

(a) Verification of Licensure — Individual Requests (1-4 Licenses) — $10 per license.

(b) Verification of Licensure — Multiple (5 or more) — $7.50 per license.

(c) Malpractice Report — Individual Requests — $10 per license.

(d) Malpractice Report — Multiple (monthly report) — $15 per report.

(e) Disciplinary — Individual Requests — $10 per license.

(4) Base Service Charges for Copying — $5 + .20/page.

(5) Record Search Charges (+ copy charges in section (4) of this rule):

(a) Clerical — $20 per hour.

(b) Administrative — $40 per hour.

(c) Executive — $50 per hour.

(d) Medical — $75 per hour.

(6) Data Order Charges:

(a) Standard Licensee Data Order — $150 each.

(b) Custom Licensee Data Order — $150.00 + $40.00 per hour Administrative time.

(c) Address Label Disk — $100 each.

(7) All Board fees and fines are non-refundable and non-transferable.

(8) The Board may waive or reduce fees for public records upon written request if the Board determines that making the record available primarily benefits the general public.

+Per ORS 677.290(3), fee includes $10.00 for the Oregon Health and Science University Library.

*Collected biennially excepted where noted in the Administrative Rules.

**Per ORS 431.960-431.978, fee is assessed to licensees authorized to prescribe or dispense controlled substances in Oregon for the purpose of creating and maintaining the Prescription Drug Monitoring Program administered by the Oregon Health Authority.

***Per ORS 676.410, fee is assessed for the purpose of creating and maintaining a healthcare workforce data base administered by the Oregon Health Authority.

****Per ORS 181.534(9)(g), fee is the actual cost of acquiring and furnishing criminal offender information.

Stat. Auth.: ORS 181.534, 431.972, 676.410, 677.265 & 677.290

Stats. Implemented: ORS 181.534, 192.440, 431.972, 676.410, 677.265 & 677.290

Hist.: ME 7-1984, f. & ef. 1-26-84; ME 17-1984, f. & ef. 11-5-84; ME 6-1985, f. & ef. 7-30-85; ME 3-1986(Temp), f. & ef. 4-23-86; ME 4-1986, f. & ef. 4-23-86; ME 9-1986, f. & ef. 7-31-86; ME 2-1987, f. & ef. 1-10-87; ME 7-1987(Temp), f. & ef. 1-26-87; ME 9-1987, f. & ef. 4-28-87; ME 25-1987, f. & ef. 11-5-87; ME 9-1988, f. & cert. ef. 8-5-88; ME 14-1988, f. & cert. ef. 10-20-88; ME 1-1989, f. & cert. ef. 1-25-89; ME 5-1989 (Temp), f. & cert. ef. 2-16-89; ME 6-1989, f. & cert. ef. 4-27-89; ME 9-1989(Temp), f. & cert. ef. 8-1-89; ME 17-1989, f. & cert. ef. 10-20-89; ME 4-1990, f. & cert. ef. 4-25-90; ME 9-1990, f. & cert. ef. 8-2-90; ME 5-1991, f. & cert. ef. 7-24-91; ME 11-1991(Temp), f. & cert. ef. 10-21-91; ME 6-1992, f. & cert. ef. 5-26-92; ME 1-1993, f. & cert. ef. 1-29-93; ME 13-1993, f. & cert. ef. 11-1-93; ME 14-1993(Temp), f. & cert. ef. 11-1-93; ME 1-1994, f. & cert. ef. 1-24-94; ME 6-1995, f. & cert. ef. 7-28-95; ME 7-1996, f. & cert. ef. 10-29-96; ME 3-1997, f. & cert. ef. 11-3-97; BME 7-1998, f. & cert. ef. 7-22-98; BME 7-1999, f. & cert. ef. 4-22-99; BME 10-1999, f. 7-8-99, cert. ef. 8-3-99; BME 14-1999, f. & cert. ef. 10-28-99; BME 4-2000, f. & cert. ef. 2-22-00; BME 6-2001(Temp), f. & cert. ef. 7-18-01 thru 11-30-01; BME 10-2001, f. & cert. ef. 10-30-01; BME 8-2003, f. & cert. ef. 4-24-03; BME 16-2003, f. & cert. ef. 10-23-03; BME 17-2004, f. & cert. ef. 9-9-04; BME 6-2005, f. & cert. ef. 7-20-05; BME 15-2006, f. & cert. ef. 7-25-06; BME 1-2007, f. & cert. ef. 1-24-07; BME 1-2008, f. & cert. ef. 1-22-08; BME 15-2008, f. & cert. ef. 7-21-08; BME 1-2009, f. & cert. ef. 1-22-09; BME 15-2009(Temp), f. & cert. ef. 9-11-09 thru 3-8-10; BME 1-2010, f. & cert. ef. 1-26-10; OMB 10-2011(Temp), f. & cert. ef. 7-13-11 thru 1-4-12; OMB 18-2011(Temp), f. & cert. ef. 10-13-11 thru 4-10-12; OMB 22-2011, f. & cert. ef. 10-18-11; OMB 33-2011(Temp), f. 12-28-11, cert. ef. 1-1-12 thru 6-29-12; OMB 3-2012, f. & cert. ef. 2-10-12; OMB 9-2012(Temp), f. & cert. ef. 3-2-12 thru 8-29-12; OMB 20-2012, f. & cert. ef. 8-3-12; OMB 27-2012(Temp), f. 10-12-12 thru 4-10-13; OMB 5-2013, f. & cert. ef. 4-5-13; OMB 13-2013(Temp), f. 7-12-13, cert. ef. 7-15-13 thru 1-11-14

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Rule Caption: Memorializes the licensing authority previously delegated to the Executive Director and Medical Director
Adm. Order No.: OMB 14-2013(Temp)
Filed with Sec. of State: 7-12-2013
Certified to be Effective: 7-15-13 thru 1-11-14
Notice Publication Date:
Rules Adopted: 847-008-0003
Subject: The temporary rule adoption puts into administrative rule the licensing authority that has been previously delegated by the Board to the Executive Director and Medical Director.
Rules Coordinator: Nicole Krishnaswami—(971) 673-2667

847-003-0008
Delegation of Authority

(1) The Executive Director or, in the absence of the Executive Director, the Medical Director has the authority to grant, renew and reactivate licensure for all license types and statuses upon satisfactory completion of the application.

(2) The Executive Director or, in the absence of the Executive Director, the Medical Director has the authority to approve visiting physician applications and visiting acupuncturist applications.

(3) The Executive Director has the authority to waive the registration fee for good and sufficient reason.

(4) The Executive Director has the authority to require additional documentation or explanatory statements for the application file to be considered satisfactorily complete.

(5) The Executive Director has the authority to determine that an applicant qualifies for licensure by expedited endorsement.

(6) The Executive Director has the authority to perform initial reviews of applications to determine whether an applicant or licensee meets the qualifications, has satisfactorily completed the application and should be approved or whether the application file contains derogatory information that requires review by an advisory committee and a determination by the Board.

(7) The Executive Director has the authority to perform initial reviews of re-entry plans for applicants who have ceased clinical practice for a period of 24 or more consecutive months to determine whether the proposed re-entry plan meets the Board's guidelines for re-entry or whether the proposal requires review by an advisory committee and a determination by the Board.

(8) The Medical Director has the authority to determine whether an applicant or licensee has significant malpractice claims or patient care issues that require additional review by an advisory committee and a determination by the Board.

(9) The Executive Director has the authority to grant waivers of the competency examinations if the applicable waiver requirements are met.

Stat. Auth.: ORS 677.235

Stats. Implemented: ORS 292.495, 677.235

Hist.: OMB 14-2013(Temp), f. 7-12-13, cert. ef. 7-15-13 thru 1-11-14

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Rule Caption: Fee for criminal records checks as approved
Adm. Order No.: OMB 15-2013(Temp)
Filed with Sec. of State: 7-12-2013

Certified to be Effective: 7-15-13 thru 1-11-14
Notice Publication Date:
Rules Amended: 847-008-0068
Subject: The temporary rule amendment specifies that the criminal records check cost will be passed through to the applicant or licensee as approved by the legislature in the 2013-15 budget.
Rules Coordinator: Nicole Krishnaswami—(971) 673-2667

847-008-0068
State and Nationwide Criminal Records Checks, Fitness Determinations

(1) The purpose of these rules is to provide for the reasonable screening of applicants and licensees in order to determine if they have a history of criminal behavior such that they are not fit to be granted or renewed a license that is issued by the Board.

(2) These rules are to be applied when evaluating the criminal history of an applicant or licensee and conducting fitness determinations based upon such history. The fact that an applicant or licensee has cleared the criminal history check does not guarantee the granting or renewal of a license.

(3) The Board may require legible fingerprints of all applicants for a medical (MD/DO), podiatric (DPM), physician assistant (PA), and acupuncturist (LAc) license, licensees reactivating their license, licensees renewing their license and licensees under investigation to determine the fitness of an applicant or licensee. These fingerprints will be provided on prescribed forms made available by the Board. Fingerprints may be obtained at a law enforcement office or at a private service acceptable to the Board; the Board will submit fingerprints to the Oregon Department of State Police to conduct a Criminal History Check and a National Criminal History Check. Any original fingerprint cards will subsequently be destroyed.

(4) The Board will determine whether an applicant or licensee is fit to be granted a license based on the criminal records background check, any false statements made by the applicant or licensee regarding the criminal history of the individual, any refusal to submit or consent to a criminal records check including fingerprint identification, and any other pertinent information obtained as part of an investigation. If an applicant is determined to be unfit, the applicant may not be granted a license. If the licensee is determined to be unfit, the licensee's license may not be reactivated or renewed. The Board may make a fitness determination conditional upon applicant's or licensee's acceptance of probation, conditions, limitations, or other restrictions upon licensure.

(5) In making the fitness determination, the Board will consider:

(a) The nature of the crime;

(b) The facts that support the conviction or pending indictment or that indicate the making of the false statement;

(c) The relevancy, if any, of the crime or the false statement to the specific requirements of the applicant's or licensee's present or proposed license; and

(d) Intervening circumstances relevant to the responsibilities and circumstances of the license. Intervening circumstances include but are not limited to:

(A) The passage of time since the commission of the crime;

(B) The age of the applicant or licensee at the time of the crime;

(C) The likelihood of a repetition of offenses or of the commission of another crime;

(D) The subsequent commission of another relevant crime;

(E) Whether the conviction was set aside and the legal effect of setting aside the conviction; and

(F) A recommendation of an employer.

(6) All background checks must include available state and national data, unless obtaining one or the other is an acceptable alternative.

(7) In order to conduct the Oregon and National Criminal History Check and fitness determination, the Board may require additional information from the licensee or applicant as necessary, such as but not limited to, proof of identity; residential history; names used while living at each residence; or additional criminal, judicial or other background information.

(8) Criminal offender information is confidential. Information received may be disseminated only to people with a demonstrated and legitimate need to know the information. The information is part of the investigation of an applicant or licensee and as such is confidential pursuant to ORS 676.175(1).

(9) The Board will permit the individual for whom a fingerprint-based criminal records check was conducted to inspect the individual's own state and national criminal offender records and, if requested by the subject individual, provide the individual with a copy of the individual's own state and national criminal offender records.

(10) The Board may consider any conviction of any violation of the law for which the court could impose a punishment and in compliance with ORS 670.280. The Board may also consider any arrests and court records that may be indicative of an individual's inability to perform as a licensee with care and safety to the public.

(11) If an applicant or licensee is determined not to be fit for a license, the applicant or licensee is entitled to a contested case process pursuant to ORS 183.414–183.470. Challenges to the accuracy or completeness of information provided by the Oregon Department of State Police, Federal Bureau of Investigation and agencies reporting information must be made through the Oregon Department of State Police, Federal Bureau of Investigation, or reporting agency and not through the contested case process pursuant to ORS 183.

(12) If the applicant discontinues the application process or fails to cooperate with the criminal history check process, the application is considered incomplete.

(13) The applicant or licensee must pay a criminal records check fee.

Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 181.534, 677.100 & 677.265
Hist. BME 20-2006(Temp), f. & cert. ef. 9-14-06 thru 3-12-07; BME 4-2007, f. & cert. ef. 1-24-07; BME 4-2008, f. & cert. ef. 1-22-08; OMB 20-2011(Temp), f. & cert. ef. 10-13-11 thru 4-10-12; OMB 5-2012, f. & cert. ef. 2-10-12; OMB 10-2012(Temp), f. & cert. ef. 3-2-12 thru 8-29-12; OMB 24-2012, f. & cert. ef. 8-3-12; Renumbered from 847-020-0155 by OMB 6-2013, f. & cert. ef. 4-5-13; OMB 15-2013(Temp), f. 7-12-12, cert. ef. 7-15-13 thru 1-11-14

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Rule Caption: Corrects the licensing process for Limited License, Medical Faculty
Adm. Order No.: OMB 16-2013(Temp)
Filed with Sec. of State: 7-12-2013
Certified to be Effective: 7-15-13 thru 1-11-14
Notice Publication Date:
Rules Amended: 847-010-0063
Subject: The temporary rule amendment accurately reflects that the Limited License, Medical Faculty is approved weekly rather than quarterly as a result of the delegation of these license application approvals to the Executive Director in July 2010.
Rules Coordinator: Nicole Krishnaswami—(971) 673-2667

847-010-0063
Limited License, Medical Faculty

(1) A physician qualifying under OAR 847-020-0140 may be granted a Limited License, Medical Faculty. This license allows the physician to practice medicine only to the extent that such practice is incident to and a necessary part of the applicant's duties as approved by the Board in connection with the faculty position.

(2) A Limited License, Medical Faculty is valid for one year after issuance and may be renewed as frequently as needed for a total period not to exceed four years. The four years must be consecutive.

(3) Every physician who is issued a Limited License, Medical Faculty to practice in this state and who intends to continue practice in such faculty position beyond the period granted for the license must submit a new limited license application and fee at least 30 days before the expiration date of the license.

Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.100 & 677.132
Hist.: ME 21-1987, f. & ef. 10-29-87; ME 11-1988, f. & cert. ef. 8-5-88; ME 4-1993, f. & cert. ef. 4-22-93; BME 5-2001, f. & cert. ef. 4-23-01; BME 2-2002, f. & cert. ef. 1-28-02; BME 5-2004, f. & cert. ef. 4-22-04; BME 3-2007, f. & cert. ef. 1-24-07; BME 23-2008, f. & cert. ef. 10-31-08; OMB 16-2013(Temp), f. 7-12-13, cert. ef. 7-15-13 thru 1-11-14

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Rule Caption: Supervising physician application fee and physician assistant surcharge fee as approved
Adm. Order No.: OMB 17-2013(Temp)
Filed with Sec. of State: 7-12-2013
Certified to be Effective: 7-15-13 thru 1-11-14
Notice Publication Date:
Rules Amended: 847-050-0027, 847-050-0042
Subject: As approved by the legislature in the 2013-15 budget, the temporary rule amendment specifies that there is a fee for the supervising physician application and implements a one-time surcharge for physician assistants renewing or applying for initial licensure in the 2014-15 licensure biennium.
Rules Coordinator: Nicole Krishnaswami—(971) 673-2667

847-050-0027
Approval of Supervising Physician

(1) Prior to using the services of a physician assistant under a practice agreement, a supervising physician or primary supervising physician of a supervising physician organization must be approved as a supervising physician by the Board.

(2) The primary supervising physician of a supervising physician organization must apply as a supervising physician with the Board and must attest that each supervising physician in the supervising physician organization has reviewed statutes and rules relating to the practice of physician assistants and the role of a supervising physician.

(3) Physicians applying to be a supervising physician or the primary supervising physician of a supervising physician organization must:

(a) Submit a supervising physician application and application fee; and

(b) Take an online course and pass an open-book exam on the supervising physician requirements and responsibilities given by the Board. A passing score on the exam is 75%. If the supervising physician applicant fails the exam three times, the physician's application will be reviewed by the Board. A supervising physician applicant who has failed the exam three times must also attend an informal meeting with a Board member, a Board investigator and/or the Medical Director of the Board to discuss the applicant's failure of the exam, before being given a fourth and final attempt to pass the examination. If the applicant does not pass the exam on the fourth attempt, the physician's application may be denied.

(4) The physician may be subject to Board investigation prior to approval or may be limited or denied approval as a supervising physician for the following:

(a) There are restrictions upon or actions against the physician's license;

(b) Fraud or misrepresentation in applying to use the services of a physician assistant.

(5) The Board may defer taking action upon a request for approval as a supervising physician pending the outcome of the investigation of the physician for violations of ORS 677.010-990.

(6) Failure to apply and be approved as a supervising physician by the Board prior to using the services of a physician assistant under a practice agreement is a violation of ORS 677.510 and is grounds for a $195 fine. The licensee may be subject to further disciplinary action by the Board.

Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.205 & 677.510
Hist.: ME 4-1981(Temp), f. & ef. 10-20-81; ME 2-1982, f. & ef. 1-28-82; ME 5-1984, f. & ef. 1-20-84; ME 8-1985, f. & ef. 8-5-85; ME 5-1986, f. & ef. 4-23-86; ME 21-1989, f. & cert. ef. 10-20-89; ME 2-1990, f. & cert. ef. 1-29-90; ME 5-1994, f. & cert. ef. 1-24-94; ME 9-1995, f. & cert. ef. 7-28-95; BME 13-2003, f. & cert. ef. 7-15-03; OMB 2-2011, f. & cert. ef. 2-11-11; [OMB 21-2011(Temp), f. & cert. ef. 10-13-11 thru 4-10-12; Suspend temporary by OBDD 28-2011(Temp), f. & cert. ef. 10-26-11 thru 4-10-12]; OMB 32-2011(Temp), f. 12-15-11, cert. ef. 1-1-12 thru 6-29-12; OMB 7-2012, f. & cert. ef. 2-10-12; OMB 11-2012(Temp), f. & cert. ef. 3-2-12 thru 8-29-12; OMB 26-2012, f. & cert. ef. 8-3-12; OMB 2-2013, f. & cert. ef. 1-11-13; OMB 17-2013(Temp), f. 7-12-13, cert. ef. 7-15-13 thru 1-11-14

847-050-0042
Registration

(1) The registration renewal form and fee must be received in the Board office during regular business hours and must be satisfactorily complete on or before December 31 of each odd-numbered year in order for the physician assistant's registration to be renewed for the next 24 months. This application must also include submission of an updated practice agreement or validation of an existing practice agreement or Board-approved practice description.

(2) Upon failure to comply with section (1) of this rule, the license will automatically lapse as per ORS 677.228.

(3) A one-time surcharge is required for each physician assistant renewing his or her license for the 2014-2015 biennial registration period or applying for an initial license during calendar years 2014 and 2015.

Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.510 & 677.512
Hist.: ME 1-1979, f. & ef. 1-2-79; ME 5-1979, f. & ef. 11-30-79; ME 4-1980(Temp), f. 8-5-80, ef. 8-6-80; ME 7-1980, f. & ef. 11-3-80; ME 4-1981(Temp), f. & ef. 10-20-81; ME 2-1982, f. & ef. 1-28-82; ME 7-1984, f. & ef. 1-26-84; ME 2-1990, f. & cert. ef. 1-29-90; ME 7-1990, f. & cert. ef. 4-25-90; ME 7-1991, f. & cert. ef. 7-24-91; ME 5-1994, f. & cert. ef. 1-24-94; BME 6-2003, f. & cert. ef. 1-27-03; BME 25-2008, f. & cert. ef. 10-31-08; [OMB 21-2011(Temp), f. & cert. ef. 10-13-11 thru 4-10-12; Suspend temporary by OBDD 28-2011(Temp), f. & cert. ef. 10-26-11 thru 4-10-12]; OMB 32-2011(Temp), f. 12-15-11, cert. ef. 1-1-12 thru 6-29-12; OMB 7-2012, f. & cert. ef. 2-10-12; OMB 17-2013(Temp), f. 7-12-13, cert. ef. 7-15-13 thru 1-11-14

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Rule Caption: Corrects the term of office for members of the Acupuncture Advisory Committee
Adm. Order No.: OMB 18-2013
Filed with Sec. of State: 7-12-2013
Certified to be Effective: 7-12-13
Notice Publication Date: 5-1-2013
Rules Amended: 847-070-0050
Subject: The rule amendment corrects the term of office for members of the Acupuncture Advisory Committee, specifies that the Committee elects its own chairperson, and provides the statutory authority for Committee member compensation and expenses.
Rules Coordinator: Nicole Krishnaswami—(971) 673-2667

847-070-0050
Acupuncture Advisory Committee

(1) An Acupuncture Advisory Committee is established. The committee must consist of six members appointed by the Board. The Board must appoint one of its members, two physicians, and three acupuncturists licensed by the Board. The acupuncture members may be appointed from nominations of the Oregon Association of Acupuncture and Oriental Medicine and other professional acupuncture organizations.

(2) The term of office of a member of the committee is three years, and members may be reappointed to serve not more than two terms. Vacancies in the committee must be filled by appointment by the Board for the balance of the unexpired term, and each member must serve until a successor is appointed and qualified.

(3) The Board may remove any member from the committee.

(4) The committee elects its own chairperson with such powers and duties as fixed by the committee.

(5) The committee members are entitled to compensation and expenses as provided for Board members in ORS 677.235.

Stat. Auth.: ORS 677.265 & 677.759
Stats. Implemented: ORS 677.235, 677.265, 677.759 & 677.780
Hist.: ME 4-1995, f. & cert. ef. 5-3-95; ME 10-1996, f. & cert. ef. 10-29-96; BME 15-1998, f. & cert. ef. 10-26-98; BME 14-2001, f. & cert. ef. 10-30-01; BME 19-2007, f. & cert. ef. 10-24-07; OMB 16-2011, f. & cert. ef. 7-13-11; OMB 18-2013, f. & cert. ef. 7-12-13

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Rule Caption: Authorizes Executive Director and Medical Director to approve suspensions and terminations by operation of law
Adm. Order No.: OMB 19-2013
Filed with Sec. of State: 7-12-2013
Certified to be Effective: 7-12-13
Notice Publication Date: 5-1-2013
Rules Adopted: 847-001-0035
Subject: The rule delegates authority to the Executive Director and Medical Director to approve Suspensions and Terminations of Orders that occur by operation of law. Currently, Suspensions that occur by operation of law are those required by statute for licensees who are in arrears for child support, licensees who do not comply with CME audit requirements, licensees who are adjudged to be mentally ill or admitted to a treatment facility for mental illness for more than 25 consecutive days, and licensees who are inmates in a penal institution. Currently, Terminations of Orders that occur by operation of law are those required by statute for licensees who come into compliance with child support or come into compliance with the CME audit requirements after the minimum 90 day suspension.
Rules Coordinator: Nicole Krishnaswami—(971) 673-2667

847-001-0035
Approval of Suspensions and Terminations of Orders by Operation of Law

(1) The Executive Director or Medical Director has the authority to grant approval of Suspensions or Terminations of Orders that occur by operation of law.

(2) The Executive Director's or Medical Director's signature grants approval of the Suspension or Termination of Order, which becomes a public document. As a public document, the Suspension or Termination of Order may be released to the public.

(3) The Executive Director or Medical Director must forward Suspensions and Terminations of Orders to the Board in a timely manner.

Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 25.750, 25.774, 677.190, 677.225 & 677.265
Hist.: OMB 19-2013, f. & cert. ef. 7-12-13

Rule Caption: Reorganizes and updates the rules for podiatry licensure
Adm. Order No.: OMB 20-2013
Filed with Sec. of State: 7-12-2013
Certified to be Effective: 7-12-13
Notice Publication Date: 5-1-2013
Rules Adopted: 847-080-0021, 847-080-0028
Rules Amended: 847-080-0002, 847-080-0010, 847-080-0013, 847-080-0017, 847-080-0018, 847-080-0022, 847-080-0030
Subject: The rule amendments update the name of the licensing examination, clarify that applicants must pass the MPA and DEA exams and a criminal records check, streamline and clarify the qualifications and documentation requirements to reflect a simplified application process that has evolved with advancements in technology and availability of electronic documents, and clarify the requirement for a clinical competency assessment for applicants who have not had sufficient postgraduate training or specialty board certification or recertification within the past 10 years.
Rules Coordinator: Nicole Krishnaswami—(971) 673-2667

847-080-0002
Application for Licensure

(1) When applying for licensure the applicant must submit to the Board the completed application, fees, documents and letters.

(2) A person applying for licensure under these rules who has not completed the licensure process within a 12 month consecutive period must file a new application, documents, letters and pay a full filing fee as if filing for the first time.

(3) The applicant may be required to appear before the Board for a personal interview regarding information received during the processing of the application.

Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.100, 677.265, 677.810 & 677.840
Hist.: ME 6-1986, f. & ef. 4-23-86; ME 3-1990, f. & cert. ef. 1-29-90; BME 8-2007, f. & cert. ef. 1-24-07; OMB 20-2013, f. & cert. ef. 7-12-13

847-080-0010
Requirements for Licensure

The applicant for licensure must have:

(1) Graduated from a school or college of podiatric medicine accredited by the Council on Podiatric Medical Education (CPME) of the American Podiatric Medical Association.

(2) Successfully passed a licensing examination as provided in OAR 847-080-0018.

(3) Fulfilled one of the following:

(a) Satisfactory completion of one year of post-graduate training served in a hospital that is approved by the CPME, or

(b) Satisfactory completion of one year of post-graduate training in a hospital residency program that was not approved by the CPME and current certification by the American Board of Podiatric Medicine or the American Board of Podiatric Surgery.

(4) Satisfactorily met the requirements of ORS 677.820 and 677.825.

Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.820, 677.825 & 677.830
Hist.: ME 4-1982, f. & ef. 4-23-82; ME 7-1982, f. & ef. 10-27-82; Suspended by ME 3-1983(Temp), f. & ef. 10-3-83 to 10-7-83; Suspended by ME 2-1984(Temp), f. & ef. 1-20-84; ME 11-1985, f. & ef. 8-6-85; ME 6-1986, f. & ef. 4-23-86; ME 8-1994, f. & cert. ef. 4-29-94; BME 16-2004, f. & cert. ef. 7-13-04; BME 13-2005, f. & cert. ef. 10-12-05; BME 18-2006, f. & cert. ef. 7-25-06; BME 12-2008, f. & cert. ef. 4-24-08; BME 27-2008, f. & cert. ef. 10-31-08; OMB 20-2013, f. & cert. ef. 7-12-13

847-080-0013
Documents to Be Submitted for Licensure

The documents submitted must be legible and no larger than 8 1/2" x 11". All documents and photographs will be retained by the Board as a permanent part of the application file. If original documents are larger than 8 1/2" x 11", the copies must be reduced to the correct size with all wording and signatures clearly shown. Official translations are required for documents issued in a foreign language. The following documents are required:

(1) Application: Completed formal application provided by the Board. Required dates must include month, day and year.

(2) Birth Certificate: A copy of birth certificate.

(3) Doctor of Podiatric Medicine Diploma: A copy of a diploma showing graduation from a school of podiatry.

(4) Photograph: A close-up, passport quality photograph, front view, head and shoulders (not profile), with features distinct, taken within 90 days preceding the filing of the application.

(5) The results of a Practitioner Self-Query from the National Practitioner Data Bank sent directly to the Board by the applicant.

(6) Legible fingerprints as described in 847-008-0068 for the purpose of a criminal records background check.

(7) An applicant must pass an open-book examination on the Medical Practice Act (ORS Chapter 677) and an open-book examination on the Drug Enforcement Administration's regulations governing the use of controlled substances. If an applicant fails one or both examinations three times, the applicant must attend an informal meeting with a Board member, a Board investigator or the Medical Director of the Board to discuss the applicant's failure of the examination(s), before being given a fourth and final attempt to pass the examination(s). If the applicant does not pass the examination(s) on the fourth attempt, the applicant may be denied licensure.

(8) Any other documentation or explanatory statements as required by the Board.

Stat. Auth.: ORS 677.265 & 677.820
Stats. Implemented: ORS 181.534, 677.820, 677.825 & 677.830
Hist.: ME 6-1986, f. & ef. 4-23-86; ME 17-1987, f. & ef. 8-3-87; BME 17-2007, f. & cert. ef. 7-23-07; OMB 20-2013, f. & cert. ef. 7-12-13

847-080-0017
Letters and Official Verifications to be Submitted for Licensure

The applicant must ensure that official documents are sent to the Board directly from:

(1) The School of Podiatry:

(a) The Verification of Medical Education form, which includes: degree issued, date of degree, dates of attendance, dates and reason of any leaves of absence or repeated years, and dates, name and location of school of podiatric medicine school if a transfer student.

(b) A Dean's Letter of Recommendation, which includes a statement concerning the applicant's moral and ethical character and overall performance as a podiatric medical student. If the school attests that a Dean's Letter is unavailable or the Board determines that it is unacceptable, a copy of the transcripts may be acceptable.

(2) The Director of Podiatric Education, Chairman or other official of the residency hospital in U.S.: A currently dated original letter (a copy is not acceptable), sent directly from the hospitals in which any post-graduate training was served, which includes an evaluation of overall performance and specific beginning and ending dates of training.

(3) The Director or other official for practice and employment in hospitals, clinics, etc., in the U.S. and foreign countries: A currently dated original letter (a copy is not acceptable), sent directly from the hospital/clinic, which includes an evaluation of overall performance and specific beginning and ending dates of practice and employment.

(4) All health licensing boards in any jurisdiction where the applicant has ever been licensed; regardless of status, i.e., current, lapsed, never practiced there: Verification, sent directly from the boards, must show license number, date issued and status.

(5) Official Examination Certification: An official certification of examination scores for the American Podiatric Medical Licensing Examination (APMLE) Parts I, II and III or the National Board of Podiatric Medical Examiners (NBPME) examination Parts I, II and III is required directly from the NBPME or the Federation of Podiatric Medical Boards.

(6) Federation of Podiatric Medical Boards Disciplinary Report: A Disciplinary Report sent directly from the Federation of Podiatric Medical Boards to the Board.

(7) Any other documentation as required by the Board, including but not limited to medical records and criminal or civil records.

Stat. Auth.: ORS 677.265 & 677.820
Stats. Implemented: ORS 677.820, 677.825 & 677.830
Hist.: ME 4-1982, f. & ef. 4-23-82; ME 6-1986, f. & ef. 4-23-86; ME 17-1987, f. & ef. 8-3-87; BME 20-2004, f. & cert. ef. 10-20-04; BME 19-2006, f. & cert. ef. 7-25-06; BME 17-2007, f. & cert. ef. 7-23-07; OMB 20-2013, f. & cert. ef. 7-12-13

847-080-0018
Examination for Licensure

The applicant must base an application upon the licensing examination administered by the National Board of Podiatric Medical Examiners (NBPME). The licensing examination is limited to the American Podiatric Medical Licensing Examination (APMLE) or the NBPME examination. No application will be accepted on the basis of reciprocity or written examination, other than an examination administered by the NBPME.

(1) The applicant must pass Parts I, II and III of the licensing examination.

(2) Part III of the licensing examination may be waived if the applicant graduated from a school or college of podiatric medicine before January 1, 2001; and

(a) Is licensed as a podiatric physician in another state; or

(b) Is certified by the American Board of Podiatric Medicine (ABPM) or the American Board of Podiatric Surgery (ABPS).

(3) The score achieved on each Part of the examination must equal or exceed the figure established by the NBPME as a passing score.

(4) All three Parts of the licensing examination must be passed within a seven-year period which begins when the first Part, either Part I or Part II, is passed. An applicant who graduated from a school or college of podiatric medicine on or after January 1, 2001, and who has not passed all three Parts within the seven-year period may request a waiver of the seven-year requirement if he or she:

(a) Has current certification by the ABPM or the ABPS; or

(b) Suffered from a documented significant health condition which by its severity would necessarily cause a delay to the applicant's podiatric study; or

(c) Experienced other extenuating circumstances that do not indicate an inability to safely practice podiatric medicine as determined by the Board.

(5) The applicant who graduated from a school or college of podiatric medicine on or after January 1, 2001, must have passed Part III of the licensing examination within four attempts, whether for Oregon or for any other state. After the third failed attempt, the applicant must have completed one additional year of postgraduate training in the United States prior to readmission to the examination. The Board must approve the additional year of training to determine whether the applicant is eligible for licensure. The applicant, after completion of the required year of training, must have passed Part III on their fourth and final attempt. An applicant who has passed Part III of the licensing examination, but not within the four attempts as required, may request a waiver of this requirement if he or she has current certification by the ABPM or the ABPS.

Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.825 & 677.830
Hist.: ME 6-1986, f. & ef. 4-23-86; ME 17-1987, f. & ef. 8-3-87; ME 23-1989(Temp), f. & cert. ef. 10-20-89; ME 3-1990, f. & cert. ef. 1-29-90; ME 13-1992, f. & cert. ef. 10-22-92; ME 8-1994, f. & cert. ef. 4-29-94; ME 11-1996, f. & cert. ef. 10-29-96; BME 2-1999, f. & cert. ef. 1-26-99; BME 4-1999, f. & cert. ef. 2-17-99; BME 10-2005, f. & cert. ef. 7-20-05; BME 19-2006, f. & cert. ef. 7-25-06; BME 17-2007, f. & cert. ef. 7-23-07; BME 18-2007(Temp), f. & cert. ef. 7-23-07 thru 1-8-08; BME 22-2007, f. & cert. ef. 10-24-07; BME 12-2008, f. & cert. ef. 4-24-08; BME 27-2008, f. & cert. ef. 10-31-08; OMB 26-2011, f. & cert. ef. 10-18-11; OMB 20-2013, f. & cert. ef. 7-12-13

847-080-0021
Competency Examination and Re-Entry to Practice

(1) The applicant who has not had sufficient postgraduate training or certification or recertification with the ABPM or the ABPS within the past 10 years may be required to pass a competency examination in podiatry. The competency examination may be waived if the applicant has completed at least 50 hours of Board-approved continuing education each year for the past three years.

(2) The applicant who has ceased practice for a period of 12 or more consecutive months immediately preceding an application for licensure or reactivation may be required to pass a competency examination in podiatry. The competency examination may be waived if, subsequent to ceasing practice, the applicant has:

(a) Passed the licensing examination administered by the NBPME, or

(b) Been certified or recertified by the American Board of Podiatric Medicine (ABPM) or the American Board of Podiatric Surgery (ABPS), or

(c) Completed a Board-approved one-year residency or clinical fellowship, or

(d) Obtained continuing medical education to the Board's satisfaction.

(3) The applicant who has ceased the practice of medicine for a period of 24 or more consecutive months may be required to complete a re-entry plan to the satisfaction of the Board. The Board must review and approve a re-entry plan prior to the applicant beginning the re-entry plan. Depending on the amount of time out of practice, the applicant may be required to do one or more of the following:

(a) Pass the licensing examination;

(b) Practice for a specified period of time under a mentor/supervising podiatric physician who will provide periodic reports to the Board;

(c) Obtain certification or re-certification by the ABPM or the ABPS;

(d) Complete a re-entry program as determined appropriate by the Board;

(e) Complete one year of an accredited postgraduate or clinical fellowship training, which must be pre-approved by the Board's Medical Director;

(f) Complete at least 50 hours of Board-approved continuing medical education each year for the past three years.

(4) Licensure shall not be granted until all requirements of OAR chapter 847, division 80, are completed satisfactorily.

Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.825 & 677.830
Hist.: OMB 20-2013, f. & cert. ef. 7-12-13

847-080-0022
Qualifications to Perform Ankle Surgery

Ankle surgery must be conducted in a certified hospital or in an ambulatory surgical center certified by the Health Division. To be eligible to perform ankle surgery in the state of Oregon, the licensed podiatrist shall meet the qualifications from one of the following sections prior to being approved by the Board to perform ankle surgery:

(1) Completion of a Council on Podiatric Medical Education (CPME) approved surgical residency; board certification by the American Board of Podiatric Surgery (ABPS) in Foot and Ankle Surgery; documented clinical experience as approved by the Board; and current clinical privileges to perform reconstructive/rearfoot ankle surgery in a Joint Commission approved hospital; or

(2) Completion of a CPME approved surgical residency; and board qualified by the ABPS in Reconstructive Rearfoot/Ankle Surgery progressing to board certification in Reconstructive Rearfoot/Ankle Surgery within seven years.

Stat. Auth.: ORS 677.245
Stats. Implemented: ORS 677.812
Hist.: BM 11-2000, f. & cert. ef. 7-27-00; BME 7-2003, f. & cert. ef. 1-27-03; OMB 20-2013, f. & cert. ef. 7-12-13

847-080-0028
License Application Withdrawals

(1) The Board will consider a request by an applicant to withdraw his/her application for licensure in the State of Oregon under the following circumstances:

(a) The applicant is eligible for licensure; and

(b) The file contains no evidence of violation of any provision of ORS 677.010–677.855.

(2) An applicant may request to withdraw his/her application for licensure in the State of Oregon, and the withdrawal will be reported to the Federation of Podiatric Medical Boards under the following circumstances:

(a) The applicant is eligible for licensure; and

(b) The file contains evidence that the applicant may have violated any provision of ORS 677.010–677.855, but the Board has decided that there is an insufficient basis to proceed to formal discipline, or a licensing body in another state has imposed formal discipline or entered into a consent agreement for the same conduct, and that action has been reported to the National Practitioner Data Bank.

Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.190, 677.265 & 677.820
Hist.: OMB 20-2013, f. & cert. ef. 7-12-13

847-080-0030
Denial of License

No applicant is entitled to a podiatry license who:

(1) Has failed an examination for licensure in the State of Oregon;

(2) Has had a license revoked or suspended in this or any other state or country unless the said license has been restored or reinstated and the applicant's license is in good standing in the state or country which had revoked the same;

(3) Has been refused a license or certificate in any other state or country on any grounds other than failure in a podiatric licensure examination;

(4) Has been guilty of conduct similar to that which would be prohibited by or to which ORS 677.190 would apply; or

(5) Has been guilty of cheating or subverting the podiatric licensing examination process. Podiatric licensing examination means any examination given by the Board, other states, or national testing organization, to an applicant for registration, certification or licensure under this act. Evidence of cheating or subverting includes, but is not limited to:

(a) Copying answers from another examinee or permitting one's answers to be copied by another examinee during the examination;

(b) Having in one's possession during the examination any books, notes, written or printed materials or data of any kind, other than examination materials distributed by Board staff, which could facilitate the applicant in completing the examination;

(c) Communicating with any other examinee during the administration of the examination;

(d) Removing from the examining room any examination materials;

(e) Photographing or otherwise reproducing examination materials.
Stat. Auth.: ORS 677.265
Stats. Implemented: ORS 677.190 & 677.265
Hist.: ME 4-1982, f. & ef. 4-23-82; ME 11-1985, f. & ef. 8-6-85; ME 6-1986, f. & ef. 4-23-86; OMB 20-2013, f. & cert. ef. 7-12-13

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Oregon Patient Safety Commission
Chapter 325

Rule Caption: Establishes the Patient Safety Commission's 2013–2015 biennial budget by amending OAR 325-005-0015.
Adm. Order No.: PSC 2-2013
Filed with Sec. of State: 7-3-2013
Certified to be Effective: 7-3-13
Notice Publication Date: 6-1-2013
Rules Amended: 325-005-0015
Subject: In accordance with the rules governing semi-independent state agencies, this action establishes the Oregon Patient Safety Commission 2013–2015 biennial budget of $2,844,268 by amending OAR 325-005-015.
Rules Coordinator: Bethany A. Walmsley—(503) 224-9226

325-005-0015
Biennial Budget

The Commission hereby adopts by reference the Oregon Patient Safety Commission 2013-2015 Biennial Budget of $2,844,268 covering the period July 1, 2013, through June 30, 2015. The Commission's Executive Director will amend budgeted accounts as necessary, within the approved budget of $2,844,268 for the effective operation of the Commission. The Commission will not exceed the approved 2013–2015 Biennium Budget without amending this rule, notifying interested parties, and holding a public hearing as required by ORS Chapter 182.462. Copies of the budget are available from the Commission's office and are posted on the Commission's website.

Stat. Auth.: ORS 442.820 & Sec. 9 Ch. 686 OL 2003
Stats. Implemented: ORS 183.453(1), 183.453(2)
Hist.: PSC 1-2006, f. & cert. ef. 2-6-06; PSC 4-2007, f. & cert. ef. 7-2-07; PSC 1-2009, f. & cert. ef. 6-26-09; PSC 1-2011, f. & cert. ef. 7-1-11; PSC 1-2012, f. 3-27-12, cert. ef. 4-1-12; PSC 1-2013, f. & cert. ef. 4-25-13; PSC 2-2013, f. & cert. ef. 7-3-13

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Oregon State Lottery
Chapter 177

Rule Caption: Amends rules for Lottery second chance drawings, promotions, giveaways, player loyalty programs, housekeeping changes
Adm. Order No.: LOTT 2-2013
Filed with Sec. of State: 6-24-2013
Certified to be Effective: 7-1-13
Notice Publication Date: 3-1-2013
Rules Amended: 177-010-0003, 177-040-0050, 177-040-0200, 177-046-0015, 177-046-0080, 177-046-0100, 177-046-0110, 177-046-0140, 177-050-0002, 177-050-0024, 177-050-0025, 177-050-0100, 177-051-0000, 177-051-0010, 177-051-0030, 177-051-0035, 177-051-0040, 177-051-0120, 177-051-0130, 177-052-0000, 177-052-0010, 177-052-0020, 177-052-0030, 177-052-0040, 177-052-0050, 177-052-0060, 177-052-0070, 177-070-0005
Rules Repealed: 177-010-0003(T), 177-040-0050(T), 177-040-0200(T), 177-046-0015(T), 177-046-0080(T), 177-046-0100(T), 177-046-0110(T), 177-046-0140(T), 177-050-0002(T), 177-050-0024(T), 177-050-0025(T), 177-050-0100(T), 177-051-0000(T), 177-051-0010(T), 177-051-0030(T), 177-051-0035(T), 177-051-0040(T), 177-051-0120(T), 177-051-0130(T), 177-052-0000(T), 177-052-0010(T), 177-052-0020(T), 177-052-0030(T), 177-052-0040(T), 177-052-0050(T), 177-052-0060(T), 177-052-0070(T), 177-070-0005(T)
Subject: The Oregon State Lottery amended these rules to add a definition of "second chance drawing"; amend the definition of "prize"; require a retailer to return non-winning tickets to the player; prohibit Lottery retailers from conducting second chance drawings using non-winning Lottery tickets; clarify that the Lottery or its authorized drawing agent may conduct drawings; prohibit multiple ownership of non-winning Lottery tickets submitted for second chance drawings; restrict who may claim a prize in a second chance drawing to the person who submitted the entry; authorize Lottery second chance drawings using Scratch-it tickets; require retailers to return unsold Scratch-it tickets within six weeks after activations have ended for that game in order to receive credit for unsold, activated tickets; make general housekeeping updates to Division 51 Promotions; remove an unneeded reference to the awarding of points and the use of a multiplier by the Lottery for player loyalty programs; specify that a person may have only one registered membership at a time; clarify that unclaimed second chance prizes are forfeited and remain the property of the Lottery Commission; and make various housekeeping changes to the rules and correct cross references.
Rules Coordinator: Mark W. Hohlt—(503) 540-1417

177-010-0003
Definitions

(1) "Business day" means the period beginning at 5 a.m. of a calendar day and ending at 4:59 a.m. on the morning of the next calendar day.

(2) "Business week" means the period beginning at 5 a.m. on a Sunday and ending at 4:59 a.m. the following Sunday morning.

(3) "Business year" means the period beginning at 5 a.m. on the Sunday immediately following the last Saturday in June, and ending at the end of the business day of the last Saturday of the following June.

(4) "Commissioner" has that definition as defined in ORS 461.010(2).

(5) "Director" has that definition as defined in ORS 461.010(3).

(6) "Drawing coordinator" means the Lottery employee designated by the Assistant Director for Security, subject to the approval of the Director, to develop and implement procedures for conducting drawings.

(7) "Immediate family" and "family member" mean a natural person's spouse, child, brother, sister, or parent by blood or adoption.

(8) "Lottery" or "State Lottery" has that definition as defined in ORS 461.010(1).

(9) "Lottery Commission" or "Commission" has that definition as defined in ORS 461.010(4).

(10) "Lottery contract" means any contract entered into by the Lottery for the purchase, lease, or sale of goods or services.

(11) "Lottery contractor" or "contractor" has that definition as defined in ORS 461.010(9).

(12) "Lottery game" or "game" has that definition as defined in ORS 461.010(5).

(13) "Lottery game retailer" or "retailer" has that definition as defined in ORS 461.010(7).

(14) "Lottery Headquarters" means the Debbs Potts Oregon State Lottery Commission building located at 500 Airport Road SE, Salem, Oregon.

(15) "Lottery Kiosk" means a location, other than Lottery Headquarters, where Lottery tickets or shares are sold directly to the public by Lottery employees.

(16) "Lottery sales location" means a Lottery Kiosk, Lottery Headquarters, or sales by the Lottery through electronic means.

(17) "Lottery vendor" or "vendor" has that definition as defined in ORS 461.010(8).

(18) "Person" has that definition as defined in ORS 461.010(6).

(19) "Prize" means any award of economic value, monetary or otherwise, that may be distributed to a Lottery player for submitting a valid claim based on a winning Lottery ticket or share, or for a winning entry in a second chance drawing.

(20) "Retailer contract" means any written contract entered into by the Lottery with a retailer for selling Lottery tickets or shares to the public.

(21) "Second Chance Drawing" or "2nd Chance Drawing" means a drawing in which an eligible non-winning Oregon Lottery® ticket or share is submitted to the Lottery for entry into a drawing for a chance to win a prize.

(22) "Share" means an opportunity to win a prize in a Lottery game that does not use certificates or tokens, such as in Video Lottery℠ games.

(23) "Ticket" means a certificate or token of the opportunity to win a prize in a Lottery game.

(24) "Traditional Lottery games" means the following lottery games offered by the Oregon State Lottery:

(a) Scratch-its℠;

(b) Lottery Raffle Game;

(c) Megabucks℠;

(d) Pick 4℠;

(e) Lucky Lines℠;

(f) Powerball®;
(g) Sports Action℠;
(h) Scoreboard℠;
(i) Win for Life℠;
(j) Keno;
(k) Mega Millions®,
(l) Second chance drawing; and
(m) Any other Lottery game designated by the Oregon State Lottery Commission as a Traditional Lottery game.

(25) "Unclaimed prize" means any prize offered in a Lottery game which has not been submitted to the Lottery for validation and prize payment within the specified prize claim period and for which the Lottery has data or evidence that the ticket or share was sold or distributed to the public.

(26) "Video Lottery℠ game retailer" or "Video Lottery℠ retailer" has that definition as defined in ORS 461.217.

(27) "Video Lottery℠ game terminal" means a type of video device for the playing of Video Lottery℠ games which is in a console that contains a game platform with a video display and a random number generator, is connected to and monitored by a central system, and accepts cash payments to permit a person to play the Video Lottery℠ games offered on the terminal for the opportunity to win a prize. Unless the context or a specially applicable definition indicates otherwise, any reference to a "Video Lottery℠ terminal", "video lottery terminal", or "video terminal" in OAR Chapter 177, a Lottery retailer contract, or Lottery form in effect or in use on or after the effective date of this rule shall be deemed to refer to a "Video Lottery℠ game terminal" as defined in this section. Video Lottery℠ Game Terminal does not include any device determined by the Oregon State Lottery Commission not to be a Video Lottery℠ game terminal.

(28) "Website" means the Lottery's Internet address at www.oregonlottery.org, or any other website that may be specified by the Lottery for a particular promotion or promotional program.

(29) "Winner claim form" means a form provided by the Lottery to a player for the purpose of claiming a prize.

Stat. Auth.: ORS 461 & OR Const. Art. XV, § 4(4)
Stats. Implemented: ORS 461.020, 461.210, 461.215, 461.217, 461.220 & 461.250
Hist.: LOTT 10-2002(Temp), f. 9-6-02, cert. ef. 9-9-02 thru 3-6-03; LOTT 21-2002, f. & cert. ef. 11-25-02; LOTT 3-2004(Temp), f. & cert. ef. 4-6-04 thru 10-1-04; LOTT 6-2004, f. & cert. ef. 5-26-04; LOTT 3-2008, f. 6-30-08, cert. ef. 7-1-08; LOTT 7-2008, f. 10-31-08, cert. ef. 11-1-08; LOTT 6-2009, f. 9-28-09, cert. ef. 10-1-09; LOTT 7-2009, f. 9-28-09, cert. ef. 10-1-09; LOTT 6-2010, f. 3-18-10, cert. ef. 3-21-10; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-040-0050
Retailer Duties

(1) General: This rule contains duties to be performed by a Lottery retailer beyond those duties described in the Lottery retailer contract. The duties listed herein are not meant to be exclusive. Other duties and requirements for retailers may be contained elsewhere in OAR division 177, ORS Chapter 461, or in the Lottery retailer contract.

(2) All Retailers: All Lottery retailers shall:

(a) Stock Equipment: Keep all Lottery equipment on the retailer's premises stocked with a variety of Scratch-it℠ tickets, play slips, computer-generated tickets, and any other Oregon Lottery® product required to be sold. Unless exempted by the Lottery, if a Lottery retailer fails to stock or replenish these items as they are made available for sale by the Lottery, or as they are depleted because of purchase or use, the Lottery may remove the equipment.

(b) Perform Minor Maintenance: Replace ribbons, ticket stock, and clear paper jams as may be required for any of the equipment provided by the Lottery for the sale of Lottery tickets or shares.

(c) Maintain Paper Stock: Install and use only approved Lottery-provided paper stock which has been specifically assigned to the selling retailer when selling Lottery tickets and shares.

(d) Obtain Permits: Be required to arrange for and obtain all necessary permits required by federal, state, and local governments for electrical installation, electrical power, telephone service, fiber optic lines and connections, and coaxial cable and connections required to sell Lottery tickets or shares at the retail site.

(e) Pay Amounts Due: Pay the amount due to the Lottery for the sale of Lottery tickets or shares by the use of an electronic funds transfer (EFT). In most instances, this EFT shall occur at the end of the fourth day after the close of each Lottery business week. When an applicant operates multiple Lottery retail sites before the effective date of this rule, the routine date of the EFT collection may be set beyond the fourth day after the close of the business week in order to accommodate the needs of the combined sites.

(3) Traditional Lottery Game Retailers: A Lottery retailer authorized to sell traditional Lottery games is required to:

(a) Scratch-It℠ Validation: Validate a Scratch-It℠ ticket presented to the retailer by a player through equipment provided by the Lottery connected to the Lottery's central computer system. The retailer is required to destroy a winning ticket after validation and payment of the prize. Any Lottery retailer who does not destroy a winning ticket after validation and payment of the prize is liable for a prize paid by another Lottery retailer who subsequently pays the ticket. The retailer is required to return a non-winning ticket to the player.

(b) Draw Game Validation: Validate a Draw game ticket through the Draw game terminal before paying a Draw game prize.

(c) Underage Play: Monitor Lottery player-operated vending machines, as defined in OAR 177-045-0000, to prevent underage play.

(4) Video Retailers: A Video Lottery℠ game retailer is required to:

(a) Cash Slip Validation: Validate any Video Lottery℠ cash slip presented for payment that was issued at the retailer's location, through the Lottery's on-site video validation terminal before paying a Video Lottery℠ prize, except for those cash slips required to be validated and paid at Lottery Headquarters in Salem.

(b) Restrict Visibility: Restrict Video Lottery℠ game terminals from visibility from areas outside of the business and from view of dining areas or other areas where minors are permitted to linger.

(c) Age-Posted Area: Maintain Video Lottery℠ game terminals in an area of the business that is prohibited to minors. The area must be posted as such by the Oregon State Lottery or the Oregon Liquor Control Commission. This restriction against minors does not apply to minors who qualify under the exceptions permitted by the Oregon Liquor Control Commission for access to areas normally prohibited to minors.

(5) Sanctions: The Director may sanction a Lottery retailer for the loss, damage, or destruction of any winning game ticket or share. This includes, but is not limited to: Imposing a requirement for remedial training for the retailer or the retailer's employees, and any other actions for failure to perform contract duties or requirements as described in the Lottery retailer contract or OAR chapter 177.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461
Hist.: LC 4-1995, f. 4-27-95, cert. ef. 5-1-95; LOTT 5-1999(Temp), f. & cert. ef. 5-26-99 thru 6-26-99, Administrative correction 11-17-99; LOTT 6-2000, f. 7-26-00, cert. ef. 8-1-00; LOTT 11-2002(Temp), f. 9-6-02, cert. ef. 9-9-02 thru 3-6-03; LOTT 22-2002, f. & cert.. ef. 11-25-02; LOTT 3-2004(Temp), f. & cert. ef. 4-6-04 thru 10-1-04; LOTT 6-2004, f. & cert. ef. 5-26-04; LOTT 12-2008, f. 12-23-08, cert. ef. 1-1-09; LOTT 6-2009, f. 9-28-09, cert. ef. 10-1-09; LOTT 4-2010(Temp), f. 3-10-10, cert. ef. 3-15-10 thru 9-4-10; LOTT 9-2010, f. 8-30-10, cert. ef. 9-5-10; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-040-0200
Lottery Retailer Second Chance Drawings

Lottery retailers are prohibited from conducting second chance drawings for prizes which require the use of a non-winning Oregon Lottery® ticket or share as an entry into a drawing conducted or operated by the retailer.

Stat. Auth.: ORS 461 & OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.200
Hist.: LOTT 12-2001(Temp) f. & cert. ef. 9-12-01 thru 3-7-02; LOTT 14-2001, f. & cert. ef. 12-3-01; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-046-0015
Definitions

For the purposes of division 46, the following definitions apply except as otherwise specifically provided in OAR chapter 177 or unless the context requires otherwise:

(1) "Drawing" means the procedure whereby the Lottery, or a drawing agent, selects the winner or the winning combination in accordance with the rules of the game.

(2) "Drawing agent" means a Lottery vendor or other designee who, subject to the approval of the Director, is designated by the Assistant Director of Security to conduct specified drawings on behalf of the Lottery.

(3) "Electronic drawing" means any drawing that involves the use of a random number generator or other computer-driven or computer-assisted device to determine winners or winning combinations, and manual interaction is incidental to the selection process.

(4) "Electronic drawing equipment" includes any computer-driven or computer-assisted device used by the Lottery, or a drawing agent, for the purpose of determining winners or winning combinations, including, but not limited to, devices used by the Lottery's central gaming system for Lottery's Draw games, or for the Lottery's periodic internet entry, raffle, second-chance drawings, or promotional games.

(5) "Manual drawing" means any drawing that does not involve the use of a random number generator or any other computer-driven or computer–assisted device to determine winners or winning combinations, and manual interaction is primary to the selection process.

(6) "Manual equipment" includes any mechanical equipment or non-electronic method used by the Lottery, or a drawing agent, for the purpose of determining winners or winning combinations, including, but not limited, to Lottery's periodic raffle games.

(7) "Random number generator" means a computer-driven electronic device capable of producing numbers at random.

Stat. Auth.: ORS 461

Stats. Implemented: ORS 461.020, 461.210, 461.220, 461.230, 461.240, 461.250 & 461.260

Hist.: LOTT 5-2008, f. 6-30-08, cert. ef. 7-1-08; LOTT 6-2009, f. 9-28-09, cert. ef. 10-1-09; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-046-0080
Drawings

(1) Drawing Coordinator and Procedures: Subject to the approval of the Director, the Lottery's Assistant Director for Security may designate a Lottery employee as a Drawing Coordinator, and may designate a drawing agent to conduct drawings. Drawings shall be conducted pursuant to drawing procedures approved by the Lottery's Assistant Director for Security and the Director.

(2) Drawing Equipment: The Lottery may use any type of equipment or method, including electronic or manual equipment and any variety of existing or future methods or equipment, for determining the winner or winning combination in any Lottery game that involves a drawing. The Lottery shall ensure the security and integrity of any equipment used to determine a winner or winning combinations. The Lottery will approve the equipment and procedures used by any drawing agent who conducts a drawing for the Lottery.

(a) Electronic Drawing Equipment: Any electronic connections to electronic drawing equipment must be made by a secure method. The Lottery shall test the equipment periodically or as needed to ensure proper operation and lack of tampering or fraud. The Lottery shall have its random number generators, or any other computer-driven or computer-assisted device used for a drawing, statistically analyzed, tested, and certified by an independent, qualified statistician for integrity.

(b) Manual Equipment: The use of any manual equipment used by the Lottery, or a drawing agent, to determine a winner or winning combinations must comply with the provisions of ORS 461.230(2).

(c) Random Number Generators: The Lottery, or a drawing agent with Lottery approval, may use random number generators to determine winning numbers for Lottery games, and to select a winning entry in a Lottery second chance drawing.

(3) Security: Subject to the approval of the Director, the Lottery's Assistant Director for Security shall approve procedures to ensure the physical security of the Lottery's drawing equipment, and the drawing equipment used by a drawing agent, and shall specify the individuals who shall have physical access to any drawing equipment. Any random number generator, or any other computer-driven or computer-assisted device, used by the Lottery, or a drawing agent, to determine winners, winning combinations, or winning entries shall be kept in a sealed enclosure within a secure area.

(4) Drawing Errors: If, during a game drawing, an equipment failure or operator error causes an interruption in the selection of numbers, symbols, or entries, a technical difficulty will be declared. Any number drawn prior to the declaration of a technical difficulty will stand and be deemed official when verified.

(5) Delay in Payment and Resolution: The Director will delay payment of all prizes if any evidence exists or there are grounds to suspect equipment malfunction, tampering, or fraud. In such event, the Lottery will not pay any prize until the Lottery completes an investigation and the Director approves the drawing and authorizes payment. If the Director does not approve the drawing, it will be void and the Lottery, or a drawing agent, will conduct another drawing to determine the winner or the winning combinations.

Stat. Auth.: ORS 461 & OR Const. Art. XV, Sec. 4(4)

Stats. Implemented: ORS 461.020, 461.210, 461.220, 461.230, 461.240, 461.250 & 461.260

Hist.: LOTT 12-2002(Temp), f. 9-6-02, cert. ef. 9-9-02 thru 3-6-03; LOTT 23-2002, f. & cert. ef. 11-25-02; LOTT 5-2008, f. 6-30-08, cert. ef. 7-1-08; LOTT 6-2009, f. 9-28-09, cert. ef. 10-1-09; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-046-0100
Ownership of Lottery Tickets and Shares

(1) Bearer Instrument: Except for a Lottery ticket or share claimed jointly in accordance with the provisions of OAR 177-046-0110(6) of this rule, until such time as a name of an individual or individuals is placed upon a Lottery ticket or share, the ticket or share is a bearer instrument and is owned by the bearer of the ticket or share. When a name or names is placed on the ticket or share, the ticket or share ceases to be a bearer instrument and the individual whose name appears on the ticket or share is the owner of the ticket or share. Only a natural person may own a ticket or share and claim a prize.

(2) Multiple Names: Multiple individuals may jointly own, possess, and claim a prize as owners of a winning ticket or share. Multiple individuals hold the ticket or share as tenants in common. Multiple individuals may specify the percentage of ownership each person holds. Each person must hold $1.00 of the prize at a minimum.

(3) Second Chance Drawing: Notwithstanding sections (1) and (2) of this rule, only one natural person can claim ownership of a non-winning ticket or share used to enter a second chance drawing. Non-winning tickets submitted and accepted as a valid entry in a Lottery second chance drawing cannot be jointly owned. Only the person who claims ownership may submit the non-winning ticket as an entry to a second chance drawing and only that person may claim the prize if the person's entry is selected as a winning entry in a second chance drawing.

Stat. Auth.: ORS 461 & OR Const. Art. XV, Sec. 4(4)

Stats. Implemented: ORS 461.020, 461.210, 461.220, 461.230, 461.240, 461.250 & 461.260

Hist.: LOTT 12-2002(Temp), f. 9-6-02, cert. ef. 9-9-02 thru 3-6-03; LOTT 23-2002, f. & cert. ef. 11-25-02; LOTT 5-2008, f. 6-30-08, cert. ef. 7-1-08; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-046-0110
Payment of Prizes

(1) General: All winning Lottery tickets or shares may be presented to the Oregon State Lottery for payment. Winning tickets or shares for prizes of $600 or less may also be presented for payment to the appropriate Lottery retailer specified in the applicable game rule.

(2) Mailing Address: Winners who mail a winning Lottery ticket or share to the Lottery must sign the Lottery ticket or share, write the claimant's mailing address on the ticket or share, and mail it to the Oregon State Lottery, P.O. Box 14515, Salem, Oregon 97309. Registered mail is recommended.

(3) Lottery Headquarters Address: Winners who present a claim in person at the Lottery may do so by bringing the winning Lottery ticket or share to the Oregon State Lottery Headquarters, Player Services, 500 Airport Road SE, Salem, Oregon 97301 during Lottery business hours.

(4) Retailer Validation and Payment of Prizes of $600 or Less: To determine whether a Lottery ticket or share presented for payment entitles the holder to a prize, a retailer must validate the claim with the Lottery by scanning the bar code or manually entering the bar code number printed on each Lottery ticket or share into equipment provided by the Lottery, and, if authorized by the Lottery, pay the player the prize amount due.

(a) Retailer Payment: A retailer is authorized to pay a prize of $600 or less and shall pay that prize in cash or check, or any combination thereof.

(b) Lottery Payment: If a retailer's prize payment check is dishonored, the player may seek payment from the Lottery by presenting a copy of the dishonored check to the Oregon State Lottery, Player Services Office, 500 Airport Road SE, Salem, Oregon 97301 during Lottery business hours, or by mailing a copy of the dishonored check with a winner claim form to the Oregon State Lottery, P.O. Box 14515, Salem, Oregon 97309. If the Lottery determines that payment of the prize is authorized, the retailer has not paid the prize, and it is unlikely that the retailer will pay the prize, the Lottery may then issue a check to the player in the amount of the prize due less any applicable tax withholding.

(c) Retailer Sanction: A retailer that pays a prize with a check that is dishonored may be subject to termination of the Lottery Retailer Contract.

(5) Lottery Validation and Prize Payment: Upon validation of a winning Lottery ticket or share presented to the Lottery for payment, the Director may pay the amount of the prize to the player less any applicable tax withholding. If the Director determines that the ticket or share is invalid, or a non-winning ticket or share, or the claim is invalid, the Director shall deny the claim and notify the player. An invalid ticket or share will not be returned to the player and is not eligible for any second chance or promotional drawing. A non-winning ticket will only be returned to the player if the player provides return postage and a self-addressed envelope or mailing container in which to return the ticket.

(a) Lottery Prize Payment of $600 or Less: Payment may be made by check, cash card, or in cash, or any combination thereof.

(A) Lottery Headquarters: Cash prize payments made at Lottery Headquarters are limited to $50 per person per day. Any prize payment balance remaining above $50 shall be paid by check. Payment may be made in person or by mail, except that the Lottery will not mail cash.

(B) Lottery Kiosk: Cash prize payments made at a Lottery kiosk are limited to $100 per transaction. Any prize payment balance remaining above $100 shall be paid by cash card.

(C) Prizes by Mail: A winning ticket or share may be submitted to the Lottery by mail. If mailed, the player must sign the ticket or share, write the player's mailing address on the ticket or share, and mail it to the Oregon State Lottery, P.O. Box 14515, Salem, Oregon 97309. Registered mail is recommended.

(b) Lottery Prize Payment of Prizes Greater than $600: A player must claim a Lottery prize of more than $600 by:

(A) Claiming in Person: Bringing the ticket or share to the Oregon State Lottery Headquarters, Player Services Office, 500 Airport Road SE, Salem, Oregon 97301 during Lottery business hours and presenting the ticket or share to the Lottery; or

(B) Claiming by Mail: Signing the ticket or share, writing the player's mailing address on the ticket or share, completing a winner claim form, and mailing it together with the winning ticket or share to the Oregon State Lottery, P.O. Box 14515, Salem, Oregon 97309. Registered mail is recommended. The winner claim form may be obtained from any Lottery retailer, from a Lottery kiosk, from the Lottery Headquarters at the addresses listed above, or downloaded from the Lottery's website.

(c) High Tier Prize Payments: The Lottery will pay a winning ticket or share by check, or subject to OAR 177-010-0050, may pay the prize in merchandise if the prize is merchandise.

(6) Claiming Lottery Tickets or Shares Jointly: If more than one name appears on a Lottery ticket or share, or if a Lottery ticket or share is owned by two or more persons, the prize must be claimed in accordance with the following:

(a) General: All persons claiming ownership of the winning Lottery ticket or share must complete and sign the Lottery's request and release form. Each of the persons signing the form must indicate each person's proportionate share of the prize. Each person must receive at least $1.00. At least one of the persons claiming ownership of the ticket or share must sign the ticket or share. That person's signature must also appear on the request and release form. If a winning ticket or share is mailed to the Lottery Headquarters with multiple signatures on it, the Director will mail the request and release form to the claimants.

(b) Deceased Signatories: A deceased signatory who dies before signing the request and release form will be presumed to have an ownership interest equal to that of the other signatories. In the event there is a deceased signatory, the Director may withhold payment for 60 days from the date of validation to allow co-owners the opportunity to seek a declaratory ruling from a court.

(c) Relinquishment of Interest: When a person who has signed a Lottery ticket or share wishes to relinquish the person's ownership interest in the Lottery ticket or share, that person must sign the Lottery's release of ownership form relinquishing the person's ownership interest. In no event will a person be permitted to relinquish ownership interest once it is determined that the person owes money for child support or other legal attachment has taken place. Once the Lottery receives the release of ownership form, it is irrevocable.

(d) Issuance of Prize Checks to Multiple Owners: If a validated winning Lottery ticket or share is claimed by multiple owners who are sharing a single prize, the Director will issue to each person claiming a share of the prize amount, a check for the portion of the prize amount claimed by each multiple owner, the total not to exceed the total prize amount. No cash payments will be made to multiple owners. However, the Director reserves the right to issue a single prize check to an individual whose name appears on the ticket or share instead of multiple prize checks to the owners of the ticket or share if the value of each individual prize check would be less than $50 or if the number of persons claiming a share of the prize exceeds 100 people. The Lottery shall pay multiple winners of a Lottery prize only at the Lottery Headquarters in Salem. Lottery retailers are not authorized to pay multiple winners who share a single prize.

(e) Payment to Multiple Owners at Lottery Kiosk: Notwithstanding subsection (6)(d) of this rule, the Lottery may pay multiple winners of a single Lottery prize at a Lottery kiosk if the total amount of the prize is $600 or less. Payment shall be made as set forth in paragraph (5)(a)(B) of this rule.

(f) Conflicting Information or Discrepancies: If there is conflicting information or discrepancies between the names on a winning Lottery ticket or share and the names on a claim form, the Lottery may withhold prize payment until the owners resolve the conflicting information. Discrepancies include, but are not limited to: Names or addresses scratched out or erased, or unreadable or altered names or addresses.

(g) Investigations: At the discretion of the Director, the Lottery may conduct an investigation to aid in the determination of the rightful owners prior to payment of any prize.

(h) Determinations: The Director's decisions regarding the determination of a winning Lottery ticket or share, or the determination of the rightful owner or owners of a prize, or of any other dispute or matter arising from payment or awarding of prizes are final and binding on all parties.

(7) Payment of Prizes Donated Anonymously to Non-Profit Groups and Others:

(a) General: The Director may pay a prize according to written anonymous instructions received with a winning Lottery ticket or share. The recipient must be a natural person or a non-profit group as described in Section 501(c)(3) of the Internal Revenue Code.

(b) Adult Recipient: If the intended recipient is a natural person of majority, the Director will contact the person and make payment to the person in accordance with the anonymous written instructions.

(c) Minor Recipient: If the intended donation benefits a natural person who is a minor, the Director will make payment in accordance with the Oregon Uniform Transfers to Minors Act, Oregon Revised Statutes (ORS) 126.805 to 126.886.

(d) Non-Profit Group as Recipient: If the intended recipient qualifies as a non-profit group as described in Section 501(c)(3) of the Internal Revenue Code, the Director will make payment only as follows:

(A) Identification of Recipient: The Director will attempt to identify and contact the intended recipient. The intended recipient shall designate in writing an agent, (a natural person) to act on its behalf and to receive the prize payment on behalf of the recipient. The Director shall confirm both the written authorization and the agent. An intended recipient is encouraged to select a bonded agent.

(B) Appearance: The agent shall appear in person at the Lottery Headquarters in Salem to claim the prize payment on behalf of the intended recipient. The Director may confirm to the Director's satisfaction that the agent is authorized to accept the donation in the agent's own name on behalf of the intended recipient.

(C) Signature and Payment: Subsequent to receipt of acceptable identification, along with a completed claim form from the agent, and the Director's review and approval, the agent, in the presence of a duly authorized Lottery official, shall sign the agent's own name on the winning Lottery ticket or share in the place indicated on the ticket or share and immediately return it to the Lottery. The Director shall then make payment to the agent less any applicable tax withholding.

(D) Identification of Donor: If the Director can reasonably identify the donor, the Director shall not make payment as specified above, but shall instead contact the donor and notify the donor to retrieve the Lottery ticket or share upon presenting acceptable proof of identification. The donor may retrieve the winning ticket or share in person at the Lottery Headquarters in Salem upon the presentation of acceptable proof of identification. The prize, less any applicable tax withholding, will be paid to the donor upon validation of the winning ticket or share.

(e) Win for Life Prize: If the winning Lottery ticket received is a Win for Life top prize of $1,000 a week for life, the prize paid will be the lump sum guaranteed five year payment under the Win for Life game rules.

(f) Forfeiture of Unclaimed Prize: In the event that the Director is unable to locate the intended recipient or the anonymous donor, the winning Lottery ticket or share shall be retained until the end of the prize claim period. After the end of the prize claim period, the ticket or share shall constitute an unclaimed prize as described in OAR 177-010-0085 and shall be forfeited to the public purpose.

(g) Discharge of Lottery from Liability: The State of Oregon, its agents, officers, employees, and representatives, including but not limited to, the Oregon Lottery, its Director, agents, officers, employees, and representatives, are discharged of all liability upon payment of an anonymously donated prize in accordance with this rule and any applicable game rules to the extent that they do not conflict with this rule. The Lottery is not responsible in any way for the fulfillment or completion of the agreement between the intended recipient and the agent. The Lottery's decisions regarding the determination that a Lottery ticket or share donated anonymously is, or is not, a winning ticket or share or any question or dispute arising from the payment of such a prize is final and binding on all parties. In the event a question or issue arises regarding payment of a prize donated anonymously, the Director may withhold payment until the question or issue is

resolved. The Lottery, the intended recipient or custodian, if the intended recipient is a minor, or the designated agent if the intended recipient is a non-profit group, may petition a court of competent jurisdiction for judicial resolution of the matter.

(8) Second Chance Drawing Prize: Sections (6) and (7) of this rule are not applicable to a prize claim from a second chance drawing. Prizes awarded by the Lottery from second chance drawings must be claimed in accordance with the provisions of OAR 177-052-0060 and only the person who submitted the winning entry in a second chance drawing may claim and be paid the prize.

(9) Social Security Numbers: Each United States resident who is to receive a payment of winnings greater than $600 shall furnish to the Lottery the information required on the Internal Revenue Service Form W-2G (or any other form required by the IRS,) including but not limited to the winner's name, address, and social security number. This disclosure is mandatory and the authority for such disclosure is 42 USC 405(c)(2)(C), 26 CFR 31.3402(q)-1(e), and ORS 461.715(1)(a). A winner's social security number will be used for the purpose of identifying child support obligors and submitting required documents to state and federal tax authorities.

(10) Payment Decisions: The Director shall make the final decision on whether any prize is paid or any annual prize payment is made. All prizes shall be paid within a reasonable time after they are validated, unless the Director delays a prize payment. The Director may, at any time, delay any prize payment in order to review the validity of a prize claim, or review a change of circumstances relative to the prize awarded, the payee, or the claim, or review any other relevant matter that may come to the Director's attention. Except as set forth in OAR 177-098-0060, for any prize requiring annual payments, all payments after the first payment shall be made on the anniversary date of the first payment in accordance with the type of prize awarded. Any delayed annual payment will be brought up to date immediately when payment is authorized by the Director.

Stat. Auth.: ORS 461 & OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.020, 461.210, 461.220, 461.230, 461.240, 461.250 & 461.260
Hist.: LOTT 12-2002(Temp), f. 9-6-02, cert. ef. 9-9-02 thru 3-6-03; LOTT 23-2002, f. & cert. ef. 11-25-02; LOTT 10-2005(Temp), f. & cert. ef. 11-2-05 thru 4-28-06; LOTT 18-2005, f. 12-21-05, cert. ef. 12-31-05; LOTT 4-2007(Temp), f. 11-8-07, cert. ef. 11-12-07 thru 5-9-08; LOTT 1-2008, f. 3-21-08, cert. ef. 3-31-08; LOTT 7-2009, f. 9-28-09, cert. ef. 10-1-09; LOTT 6-2010, f. 3-18-10, cert. ef. 3-21-10; LOTT 9-2010, f. 8-30-10, cert. ef. 9-5-10; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-046-0140
Suspension of Play

(1) Suspension of Drawings: At the discretion of the Director, any Lottery drawing may be suspended.

(2) Refund Options: If the Director suspends a drawing after Lottery tickets or shares have been sold for that drawing, a player may receive a refund of the player's ticket or share price, or a replacement Lottery ticket or share from another Lottery game, or the Director may hold a replacement drawing at the Director's discretion.

(3) Termination of Games: A Lottery game may be discontinued at any time.

Stat. Auth.: ORS 461 & OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.020, 461.210, 461.220, 461.230, 461.240, 461.250 & 461.260
Hist.: LOTT 12-2002(Temp), f. 9-6-02, cert. ef. 9-9-02 thru 3-6-03; LOTT 23-2002, f. & cert. ef. 11-25-02; LOTT 5-2008, f. 6-30-08, cert. ef. 7-1-08; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-050-0002
Definitions

For the purposes of division 50, the following definitions apply except as otherwise specifically provided in OAR chapter 177 or unless the context requires otherwise:

(1) "Pack" means a book of shrink-wrapped Scratch-it^{SM} game tickets which may or may not be attached to each other by perforations.

(2) "Pack-Ticket Number" means the uncovered number printed on a Scratch-it^{SM} ticket which consists of a game number, a unique pack identification number, and a ticket number.

(3) "Play Symbols" mean the figures printed under each of the rub-off spots on the playing surface of a Scratch-it^{SM} ticket.

(4) "Play Symbol Caption" means the material printed below each play symbol on a Scratch-it^{SM} ticket which repeats or explains the play symbol. Only one play symbol caption is printed under each play symbol.

(5) "Retailer Validation Code" means the small letters found under the removable rub-off latex that covers the play symbols on the playing surface of a Scratch-it^{SM} ticket. The letters appear in varying locations beneath the removable rub-off latex and among the play symbols.

(6) "Scratch-it^{SM}" means a game in which winning tickets are produced at the time of manufacture with the aid of equipment, and the winning tickets are identified after purchase by scanning the bar code or manually entering the bar code number printed on each ticket with equipment provided by the Lottery. A Scratch-it^{SM} game ticket offers a player the opportunity to remove a latex covering on the playing surface of a ticket and play the Scratch-it^{SM} ticket for entertainment purposes. A non-winning Scratch-it^{SM} game ticket may also offer a player the opportunity to enter a Lottery second chance drawing for a prize in accordance with the provisions of division 52 of OAR chapter 177.

(7) "Ticket Validation Number" means the unique number covered by latex on the playing surface of a Scratch-it^{SM} ticket.

(8) "Void if Removed Number" (VIRN) means the series of digits on a Scratch-it^{SM} ticket covered with latex which is used in the validation process.

Stat. Auth.: ORS 461 & OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.010
Hist.: LC 7-1987, f. & ef. 4-29-87; LC 13-1987(Temp), f. & ef. 7-27-87; LC 15-1987, f. 8-24-87, ef. 9-1-87; LC 4-1988, f. & cert. ef. 1-26-88; LC 6-1993, f. & cert. ef. 7-2-93; LOTT 15-2001, f. & cert. ef. 12-3-01; LOTT 13-2002(Temp), f. 9-6-02, cert. ef. 9-9-02 thru 3-6-03; LOTT 24-2002, f. & cert. ef. 11-25-02; LOTT 4-2007(Temp), f. 11-8-07, cert. ef. 11-12-07 thru 5-9-08; LOTT 1-2008, f. 3-21-08, cert. ef. 3-31-08; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-050-0024
Method of Determining Winners

(1) General: Winning tickets in a Scratch-it^{SM} game are determined at the time of manufacture when winning tickets are produced at random with the aid of equipment in accordance with the payout percentage and prize structure established for the game.

(2) Determination of a Winning Ticket: To determine a winning ticket, the official bar code or bar code number printed on the ticket must be scanned or manually entered either at the Lottery's Headquarters in Salem or at a retail site by a Lottery retailer into equipment connected to the Lottery's central computer system. If the ticket is a winner, Lottery's computer system will identify it as such based upon the official bar code or bar code number. Removing the latex covering on the playing surface of the ticket does not identify a winning ticket. The latex covering feature is offered for entertainment purposes only. The ticket holder must notify the Lottery or a retailer of the apparent winning ticket and submit it for validation as specified in these rules in order to claim a prize. The ticket must be validated in accordance with Lottery's administrative rules as may be amended from time to time before a prize may be paid.

(3) Second Chance Drawings: To determine a winner of a second chance drawing, the Lottery will follow the requirements set forth in OAR 177-052-0050.

(4) Highest Prize: Only the highest prize amount will be paid on a winning Scratch-it^{SM} ticket, except for games which are designed to offer multiple prizes. In all events, the determination of prize winners is subject to the general ticket validation requirements set forth in OAR 177-050-0027 and any additional requirements set forth on each Scratch-it^{SM} ticket. If the terms on a ticket conflict with the Lottery's administrative rules, then the rules are the controlling authority.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.230
Hist.: LC 7-1987, f. & ef. 4-29-87; LC 4-1990, f. & cert. ef. 4-3-90; LC 8-1990(Temp), f. & cert. ef. 6-26-90; LC 11-1990, f. & cert. ef. 8-21-90; LC 6-1993, f. & cert. ef. 7-1-93; LOTT 15-2001, f. & cert. ef. 12-3-01; LOTT 4-2007(Temp), f. 11-8-07, cert. ef. 11-12-07 thru 5-9-08; LOTT 1-2008, f. 3-21-08, cert. ef. 3-31-08; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-050-0025
Payment of Prizes

(1) Prizes of $600 or Less: Prizes of $600 or less from winning Scratch-it^{SM} tickets shall be claimed by one of the following methods:

(a) Retailer Prize Payment: The player may present a winning Scratch-it^{SM} ticket to a Lottery retailer. The retailer shall determine whether the ticket entitles the holder to a prize, validate the claim with the Lottery by scanning the bar code or manually entering the bar code number printed on the ticket into equipment provided by the Lottery, and, if authorized by the Lottery, pay the player the prize amount due. A retailer that is authorized to pay a prize of $600 or less shall pay that prize in cash or by check, or any combination thereof.

(b) Lottery Prize Payment of $600 or Less: Upon validation of a winning ticket under OAR 177-050-0027, the Lottery will pay the amount of the prize to the player. Payment may be made by check, cash card, or in cash, or any combination thereof. If the ticket is determined to be invalid or a non-winning ticket, or the claim is invalid, the claim shall be denied and the claimant notified.

(A) Lottery Headquarters: Cash prize payments made at Lottery Headquarters are limited to $50 per person per day. Any prize payment bal-

ance remaining above $50 shall be paid by check. Payment may be made in person or by mail, except that the Lottery will not mail cash.

(B) Lottery Kiosk: Cash prize payments made at a Lottery kiosk are limited to $100 per transaction. Any prize payment balance remaining above $100 shall be paid by cash card.

(C) Prizes by Mail: A winning Scratch-it^{SM} ticket may be submitted to the Lottery by mail. If mailed, the player must sign the ticket, write the player's mailing address on the ticket, and mail it to the Oregon State Lottery, P.O. Box 14515, Salem, Oregon 97309. Registered mail is recommended.

(2) Prizes Greater than $600: A player must claim a winning Scratch-it^{SM} ticket prize of more than $600 by:

(a) Claiming in Person: Bringing the ticket to the Oregon State Lottery Headquarters, Player Services Office, 500 Airport Road SE, Salem, Oregon 97301 during Lottery business hours and presenting the ticket to the Lottery; or

(b) Claiming by Mail: Signing the ticket, writing the player's mailing address on the ticket, completing a winner claim form, and mailing it together with the winning ticket to the Oregon State Lottery, P.O. Box 14515, Salem, Oregon 97309. Registered mail is recommended. The winner claim form may be obtained from any Lottery retailer offering traditional games, from a Lottery kiosk, from the Lottery Headquarters at the addresses listed above, or downloaded from the Lottery's website.

(c) Lottery Prize Payment: Upon validation of a winning ticket under OAR 177-050-0027, the Lottery will pay by check the amount of the prize to the player, less any applicable tax withholding. If the ticket is determined to be invalid or a non-winning ticket, or the claim is invalid, the claim shall be denied and the player notified.

(3) Second Chance Drawing Prizes: Prizes awarded by the Lottery from second chance drawings must be claimed in accordance with the provisions of OAR 177-052-0060.

(4) Validation and Payment of Lost, Damaged, or Destroyed Tickets for Prizes Greater than $600: If a player of a Scratch-it^{SM} prize of more than $600 cannot submit an intact winning ticket because a Scratch-it^{SM} game retailer lost, damaged, or destroyed the ticket while attempting to perform validation procedures on the game ticket, a prize claim based on the lost, damaged, or destroyed ticket may still be validated provided the claim is made before the end of the one year claim period after the end of the game as described in OAR 177-050-0100.

(a) Player Form and Affidavit: To claim a prize based on a lost, damaged, or destroyed ticket, the player must obtain, complete, and sign a winner claim form and a claim affidavit furnished by the Lottery. The player shall submit the two completed forms along with any other evidence of the validation attempt that is in the player's possession (including, but not limited to, the "This is not a Ticket" slip produced by the terminal at the time of the validation attempt) to the Lottery at the addresses listed in section (1)(b) of this rule, either by mail (registered mail recommended) or in person at the Lottery Headquarters in Salem during Lottery business hours.

(b) Evidence: The evidence submitted by the player must corroborate the validation attempt including, but not limited to, identification of the Lottery game retailer or clerk who attempted to validate the prize, the time and date of the validation attempt, the ticket validation number, the terminal number, and the prize amount.

(c) Investigation: The Assistant Director for Security will conduct an investigation to determine if the claim and winning game ticket are valid.

(d) Retailer Affidavit: A retailer who is the subject of an investigation conducted under this section must complete and provide to the Lottery a retailer affidavit form explaining the events in question.

(e) Director's Determination: Based upon all the facts and information available, the Director shall make a determination whether prize payment is warranted and authorized.

(f) Payment of Prize: Upon the Director's determination that the ticket submitted under this section is a valid, winning ticket, and that the player is the proper person to whom a prize is payable, the Lottery shall present or mail a check to the player in payment of the appropriate prize amount less any applicable tax withholding.

(g) Restriction of Payment: Payments of claims submitted under this section are restricted to the prize amount.

(h) Retailer Sanctions: The Director may sanction a Lottery game retailer for the loss, damage, or destruction of a winning Scratch-it^{SM} game ticket including, but not limited to, imposing a requirement for training for the retailer or the retailer's employees, and any other actions that the Lottery may take in response to a retailer's failure to perform contract duties or requirements as described in the Lottery retailer contract.

(i) Notification of Denial: If the ticket is determined to be invalid or a non-winning ticket, or the claim is invalid, the claim shall be denied and the player notified.

(5) Time Limit: A prize claim for a winning Scratch-it^{SM} ticket must be made under this rule within the time limit specified in OAR 177-050-0100. A prize claim from a second chance drawing must be made within the time limit specified in OAR 177-052-0060.

(6) Invalid Tickets: Any ticket not passing all applicable validation checks is invalid and void for claims made under OAR 177-050-0025(3). A player submitting an invalid or void ticket is ineligible for any prize and no prize shall be paid for such a ticket. An invalid ticket will not be returned to the player and is not eligible for any second chance or promotional drawing.

Stat. Auth.: ORS 461, OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.020, 461.210, 461.220, 461.230, 461.240, 461.250, 461.260
Hist.: SLC 4-1985(Temp), f. & ef. 1-29-85; SLC 8-1985, f. & ef. 6-21-85; SLC 4-1986, f. & ef. 2-25-86; SLC 27-1986, f. & ef. 11-24-86; LC 7-1987, f. & ef. 4-29-87; LC 4-1990, f. & cert. ef. 4-3-90; LC 8-1993, f. 9-22-93, cert. ef. 10-18-93; LOTT 15-2001, f. & cert. ef. 12-3-01; LOTT 13-2002(Temp), f. 9-6-02, cert. ef. 9-9-02 thru 3-6-03; LOTT 24-2002, f. & cert. ef. 11-25-02; LOTT 10-2005(Temp), f. & cert. ef. 11-2-05 thru 4-28-06; LOTT 18-2005, f. 12-21-05, cert. ef. 12-31-05; LOTT 4-2007(Temp), f. 11-8-07, cert. ef. 11-12-07 thru 5-9-08; LOTT 1-2008, f. 3-21-08, cert. ef. 3-31-08; LOTT 9-2008, f. 11-21-08, cert. ef. 12-1-08; LOTT 7-2009, f. 9-28-09, cert. ef. 10-1-09; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-050-0100
Official End of Scratch-it^{SM} Ticket Games and Last Date to Claim a Prize or to Receive Credit for Unsold Scratch-it^{SM} Tickets

(1) Director's Determination: The Director shall determine the official ending date of a Scratch-it^{SM} ticket game.

(2) Notice: The Director shall announce the official ending date of each Scratch-it^{SM} ticket game by any reasonable means, which may include: Notice on the Lottery's website, media advertisements, or notice through Lottery retail sales sites.

(3) Last Date to Claim a Prize: In accordance with ORS 461.250(7), the last date to claim a prize from a winning Scratch-it^{SM} ticket is one calendar year from the official ending date of the particular Scratch-it^{SM} ticket game, unless the Lottery Commission defines a shorter time period to claim a prize in a particular Scratch-it^{SM} ticket game. A prize must be claimed by 5:00 p.m. on the last date to claim a prize and if not claimed by that date is an unclaimed prize. If the final date of the claim period falls on a day when the Oregon Lottery Headquarters is not open to the general public, such as a weekend, Lottery holiday, or furlough closure day, the claim period shall be extended until 5:00 p.m. on the next day the Oregon Lottery Headquarters is open to the general public.

(a) Second Chance Drawings: Prize claims made under second chance drawings utilizing non-winning Scratch-it^{SM} tickets must be made within the time limits specified in OAR 177-052-0060.

(4) Unsold Returns: To receive credit for unsold, activated tickets in a Scratch-it^{SM} ticket game that is ending, a retailer must return the tickets to the Lottery within six weeks following the date when the Lottery stops activating the tickets in that Scratch-it^{SM} ticket game. Lottery will announce to the Lottery retail sales sites the date the tickets will no longer be activated. Upon a showing of good cause by the retailer, the Director may authorize credit for unsold, activated Scratch-it^{SM} tickets returned beyond this six-week period.

Stat. Auth.: ORS 461 & Or. Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.020, 461.210, 461.220, 461.230, 461.240, 461.250, & 461.260
Hist.: LOTT 9-2008, f. 11-21-08, cert. ef. 12-1-08; LOTT 3-2009, f. 2-27-09, cert. ef. 3-1-09; LOTT 2-2010, f. 1-29-10, cert. ef. 2-1-10; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-051-0000
Purpose

The purpose of this division of OAR chapter 177 is to authorize and set forth the provisions for promotions, giveaways that may be conducted from time to time, and Player Loyalty Programs of the Oregon State Lottery. The rules in this division do not apply to promotions conducted by Lottery retailers or incentive programs that the Lottery may conduct for Lottery retailers.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4) & ORS 461
Stats. Implemented: ORS 461.200
Hist.: LOTT 5-2003(Temp), f. & cert. ef. 5-28-03 thru 11-21-03; LOTT 13-2003, f. & cert. ef. 9-29-03; LOTT 3-2011, f. 7-29-11, cert. ef. 8-1-11; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-051-0010
Definitions

For purposes of division 51, the following definitions apply, unless the context requires otherwise:

(1) "Drawing" means a certain type of promotion in which the Lottery, or a drawing agent, randomly selects an entry from among entrants in order to award a promotional reward or giveaway to the person whose entry is selected.

(2) "Giveaway" means Lottery-branded merchandise, cash, a coupon, or any other item of value given by the Lottery to a person as a means of promoting the sale of the Lottery's tickets and shares.

(3) "Player Loyalty Program" refers to a promotional program offered by the Lottery to encourage loyalty to Lottery products, where persons who qualify must register to become a member in order to participate in the Player Loyalty Program.

(4) "Promotion" means an activity that directly or indirectly promotes the sale of Lottery tickets or shares through use of a Player Loyalty Program, promotional rewards, giveaways, or any other item or player incentive offered by the Lottery.

(5) "Promotional Reward" means an item of value that may be awarded to a person in a promotion through a drawing.

(6) "Website" means the Lottery's Internet address at www.oregonlottery.org, or any other website that may be specified by the Lottery for a particular promotion or promotional program.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4) & ORS 461
Stats. Implemented: ORS 461.200
Hist.: LOTT 5-2003(Temp), f. & cert. ef. 5-28-03 thru 11-21-03; LOTT 13-2003, f. & cert. ef. 9-29-03; LOTT 3-2011, f. 7-29-11, cert. ef. 8-1-11; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-051-0030
Promotions

(1) Authorization: At the discretion of the Director, the Lottery may conduct promotions that directly or indirectly promote the sale of Lottery® tickets or shares.

(2) Participation: A person may participate in a promotion only if eligible, as solely determined by the Lottery. No purchase is required and there is no fee for participation in a Lottery promotion. No person may claim any right to participate in any promotion or promotional program or to receive from the Lottery any promotional reward, giveaway, or any other item of value offered by the Lottery through a promotion.

(3) Applicable Laws: A promotion is subject to all applicable laws and administrative rules related to the Lottery and to any additional terms and conditions relating to the promotion that are posted by the Lottery on its website. The Lottery may change the terms and conditions of a promotion at any time and for any reason, with or without prior notice.

(4) Void if Prohibited: Any promotion conducted by the Lottery is void where prohibited by law.

(5) Non-Transferable: Promotional rewards, giveaways, or any other items of value offered through a promotion are not transferable and a person may not assign or otherwise transfer any right to receive such items. The Lottery will not make any substitutions.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4) & ORS 461
Stats. Implemented: ORS 461.200
Hist.: LOTT 5-2003(Temp), f. & cert. ef. 5-28-03 thru 11-21-03; LOTT 13-2003, f. & cert. ef. 9-29-03; LOTT 3-2011, f. 7-29-11, cert. ef. 8-1-11; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-051-0035
Player Loyalty Program

(1) General: The Lottery may offer a Player Loyalty Program. A Player Loyalty Program is a promotional program offered by the Lottery to promote the sale of Lottery® tickets and shares. Participation by members who join as members is voluntary and for entertainment purposes only. No person may claim any right to participate in a Player Loyalty Program offered by the Lottery, nor may a person claim any right to receive a promotional reward, giveaway, or any other item of value offered by the Lottery through a Player Loyalty Program.

(2) Eligibility: A person must meet the requirements in OAR 177-051-0040 in order to become a member and be eligible to participate in a Player Loyalty Program.

(3) Membership Application: To participate in a Player Loyalty Program, a person must become a member by electronically completing a registration process that includes providing the person's name, physical address, e-mail address, and any other information required by the Lottery.

(4) Terms and Conditions: Participation in a Player Loyalty Program offered by the Lottery is subject to all terms and conditions governing the program. The terms and conditions shall be posted on the website. By applying for membership, a person expressly accepts the terms and conditions at the time the person completes the registration process. The terms and conditions may be modified at any time, with or without prior notice, even if such modification may affect a member's participation in the Player Loyalty Program or affect the member's receipt of a promotional reward, giveaway, or any other item of value offered by the Lottery under a Player Loyalty Program.

(5) Discontinuation of Program: The Lottery may discontinue a Player Loyalty Program at any time, with or without prior notice by the Lottery. Once a program is discontinued, a member's eligibility for promotional rewards, giveaways, or any other item of value offered by the Lottery under the program terminates.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4) & ORS 461
Stats. Implemented: ORS 461.200
Hist.: LOTT 3-2011, f. 7-29-11, cert. ef. 8-1-11; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-051-0040
Eligibility

(1) Requirements: To be eligible to receive any promotional reward, giveaway, or any other item of value offered in a Lottery promotion, or to participate in a Player Loyalty Program, a person must meet the following requirements:

(a) Be a natural person 18 years of age or older, unless a specific promotion or Player Loyalty Program requires the entrant to be 21 years of age or older;

(b) Must not be:

(A) An employee or representative of the Lottery, or the spouse, child, brother, sister, or parent of any such employee or representative;

(B) An employee or representative of the Oregon State Police, Gaming Enforcement Division; or

(C) A Lottery vendor who is prohibited by contract with the Lottery from participating in the promotion or is prohibited from playing Lottery games.

(c) Must accept and abide by all terms and conditions applicable to the promotion.

(2) Disqualification: If at any time the Lottery determines that a person who participates in a promotion, including, but not limited to a Player Loyalty Program, does not meet the eligibility requirements listed above, that person is disqualified. A person who is disqualified is not eligible to participate in the promotion and is not eligible to receive any promotional reward, giveaway, or any other item of value offered in the promotion. If a person who is disqualified has received a promotional reward, giveaway, or any other item of value in the promotion, the Lottery, in its sole discretion, may require the person to return the promotional reward, giveaway, or other item or incentive to the Lottery.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4) & ORS 461
Stats. Implemented: ORS 461.200
Hist.: LOTT 5-2003(Temp), f. & cert. ef. 5-28-03 thru 11-21-03; LOTT 13-2003, f. & cert. ef. 9-29-03; LOTT 3-2011, f. 7-29-11, cert. ef. 8-1-11; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-051-0120
Limitation of Liability

(1) General: The State of Oregon, its agents, officers, and employees, the Oregon State Lottery Commission, and the Oregon State Lottery, and its agents, officers, and employees, are not liable for any:

(a) Late, lost, misrouted, garbled, distorted, or damaged entries, claims, other communications, or transmissions;

(b) Telephone, electronic, hardware, software, network, Internet, or other computer, or communications-related malfunctions or failures;

(c) Promotion disruptions, any printing or typographical errors in any materials associated with a promotion;

(d) Entries, claims, or other communications not received by the Lottery, or if applicable, by a Lottery contractor, vendor, or authorized agent, or that are lost in the mail or delivered elsewhere, or are electronically misrouted or misdirected; or

(e) Other injuries, losses, or damages arising from, related to, or caused by a promotion, or any claims arising from or related to the acceptance, possession, or use of any promotional reward, giveaway, or any other item of value offered by the Lottery.

(2) Voluntary Participation: Participation in a promotion is voluntary. Acceptance of any promotional reward, giveaway, or other item of value offered in a promotion is voluntary. Promotions that require persons to compete with other persons, play games, or complete tasks, or any similar activities carry a risk of personal injury or death. Participation is at the person's own risk. The State of Oregon, its agents, officers, and employees and the Oregon State Lottery Commission and the Oregon State Lottery, its agents, officers, and employees, are not liable for any personal injury, loss, or consequential damage arising from, related to, or caused by a person's participation in any promotion. Possession, use, or participation in any activity resulting from the acceptance of a promotional reward, giveaway,

or other item of value awarded to a person by the Lottery carry a risk of personal injury or death. Such acceptance is at the person's own risk. The State of Oregon, its agents, officers, and employees and the Oregon State Lottery Commission and the Oregon State Lottery, its agents, officers, and employees, are not liable for any personal injury, loss, or consequential damage arising from, related to, or caused by a person's acceptance of any promotional reward, giveaway, or other item of value awarded to the person by the Lottery.

(3) Disputes: In the event a person disagrees with the Lottery's determination that the person is not eligible to participate in a promotion, or has not complied with the terms and conditions of a promotion, and therefore should not receive a promotional reward, giveaway, or any other item of value offered by the Lottery, the Lottery's determination is final. At the sole discretion of the Lottery, and if the person is eligible, the Lottery may provide the person with the opportunity to enter another promotion, or may provide the person a ticket or share from any current Lottery game. This is the person's sole and exclusive remedy.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4) & ORS 461
Stats. Implemented: ORS 461.200
Hist.: LOTT 5-2003(Temp), f. & cert. ef. 5-28-03 thru 11-21-03; LOTT 13-2003, f. & cert. ef. 9-29-03; LOTT 3-2011, f. 7-29-11, cert. ef. 8-1-11; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-051-0130
Miscellaneous

(1) Cancellation of Promotions: The Director may cancel or postpone any promotion at any time in the exercise of the Director's sole discretion, with or without prior notice.

(2) Conflicting Provisions: In the event of a conflict between the Lottery's rules in division 51 and the terms and conditions of any promotion, these rules control.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4) & ORS 461
Stats. Implemented: ORS 461.200
Hist.: LOTT 5-2003(Temp), f. & cert. ef. 5-28-03 thru 11-21-03; LOTT 13-2003, f. & cert. ef. 9-29-03; LOTT 3-2011, f. 7-29-11, cert. ef. 8-1-11; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-052-0000
Purpose

The purpose of this division of OAR chapter 177 is to authorize and set forth the provisions for second chance drawings that the Oregon State Lottery, or a drawing agent, may conduct from time to time.

Stat. Auth.: ORS 461 & OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.220, 461.230 & 461.250
Hist.: LOTT 5-2011(Temp), f. & cert. ef. 9-2-11 thru 1-29-12; LOTT 7-2011, f. 11-21-11, cert. ef. 12-1-11; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-052-0010
Definitions

(1) "Active Scratch-it^{SM} game" means a Lottery Scratch-it^{SM} game that has not officially ended as set forth in OAR 177-050-0100.

(2) "Entry Requirements" means the instructions that specify how to enter a second chance drawing.

Stat. Auth.: ORS 461 & OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.220, 461.230 & 461.250
Hist.: LOTT 5-2011(Temp), f. & cert. ef. 9-2-11 thru 1-29-12; LOTT 7-2011, f. 11-21-11, cert. ef. 12-1-11; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-052-0020
Eligibility

(1) Requirements: To be eligible to win a prize in a second chance drawing, a person must meet the following eligibility requirements:

(a) Be a natural person 18 years of age or older;

(b) Must reside in the United States;

(c) Must be a registered member on a Lottery designated website;

(d) Must submit a valid entry with the required information, through whichever method for entry the Lottery requires for the particular second chance drawing and by the deadline specified by the Lottery; and

(e) Must not be:

(A) An employee or representative of the Lottery, or the spouse, child, brother, sister, or parent of any such employee or representative;

(B) An employee or representative of the Oregon State Police, Gaming Enforcement Division; or

(C) A Lottery vendor who is prohibited by contract with the Lottery from participating in a second chance drawing or is prohibited from playing Lottery games.

(2) Person Ineligible: If at any time the Lottery determines that a person who submitted a second chance drawing entry does not meet the requirements listed in section (1) of this rule, that person is disqualified and is ineligible for a prize. If the Lottery determines that a person who is disqualified is the winner of a second chance drawing prize, the prize will not be awarded to the winner and becomes an unclaimed prize and is the property of the Lottery Commission to be allocated to the benefit of the public purpose.

Stat. Auth.: ORS 461 & OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.220, 461.230 & 461.250
Hist.: LOTT 5-2011(Temp), f. & cert. ef. 9-2-11 thru 1-29-12; LOTT 7-2011, f. 11-21-11, cert. ef. 12-1-11; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-052-0030
Entry Requirements

(1) Method of Entry: The Lottery will determine the method of entry for any second chance drawing, which may include, but is not limited to, electronic entry through a website, mail, or walk-in entries.

(2) Electronic Entry: To submit a valid electronic entry, a person must:

(a) Register as a member on a Lottery designated website. A person may only have one active membership at a time;

(b) Enter the Game ID number, the box code, and the ticket code from the Lottery game ticket that is eligible for the particular second chance drawing;

(c) Provide any additional information as required by the Lottery; and

(d) Submit the electronic entry prior to the deadline for submission of entries for the second chance drawing as announced by the Lottery.

(3) Confirmation of Entry: Each ticket and drawing entry must be validated through the website, and will be considered entered into the drawing once the player receives confirmation of the entry.

(4) Ticket Requirements: Only one Lottery game ticket or share may be used for each entry. If the second chance drawing specifies use of a Scratch-it^{SM} ticket for entry into the drawing, only a Lottery Scratch-it^{SM} game ticket from an active Scratch-it^{SM} game, as specified by the Lottery, is eligible for entry into the second chance drawing.

(5) Single Entrant: Only one person per entry may submit an entry for a second chance drawing. An entry with more than one name on the entry form is invalid.

(6) Other Entry Requirements: The Lottery may establish additional terms and conditions and entry requirements for any second chance drawing. These additional terms and conditions and entry requirements will be posted on a Lottery website or as otherwise announced by the Lottery.

(7) Invalid Entry: Failure to follow any of the terms and conditions or entry requirements of a second chance drawing will invalidate the entry. An invalid entry is void and is not eligible for a second chance drawing prize. Invalid entries will not be returned to the entrant. If the Lottery determines the winning entry is invalid, the prize shall be treated as an unclaimed prize and is the property of the Lottery Commission to be allocated to the benefit of the public purpose.

Stat. Auth.: ORS 461 & OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.220, 461.230 & 461.250
Hist.: LOTT 5-2011(Temp), f. & cert. ef. 9-2-11 thru 1-29-12; LOTT 7-2011, f. 11-21-11, cert. ef. 12-1-11; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-052-0040
Odds of Winning

General: The odds of winning a Lottery second chance drawing depend on the total number of entries received.

Stat. Auth.: ORS 461 & OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.220, 461.230 & 461.250
Hist.: LOTT 5-2011(Temp), f. & cert. ef. 9-2-11 thru 1-29-12; LOTT 7-2011, f. 11-21-11, cert. ef. 12-1-11; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-052-0050
Selection of Winners

(1) When Drawing Held: A Lottery second chance drawing will be held at such date, time, place, and in such manner as is determined by the Lottery and will be conducted only after the deadline for submitting entries has closed, as announced by the Lottery.

(2) Random Drawing: During the drawing for each available prize in a second chance drawing, the Lottery, or a drawing agent, will randomly select a winning entry from all the entries submitted for that drawing.

(3) Selection of Entry: To select a winning entry, the Lottery, or a drawing agent, may conduct a manual or electronic drawing, or may use any other selection procedure as determined by the Lottery Director that ensures a random selection of a winning entry.

(4) Suspension or Cancellation of Drawing: At the discretion of the Lottery Director, a second chance drawing may be suspended. If the Director suspends a drawing the Director may hold a replacement drawing or cancel the drawing. If the second chance drawing is canceled, the Lottery, in its sole discretion, may provide an entrant who entered the drawing with a coupon for a Lottery product, or a promotional reward, the value of which shall be solely determined by the Lottery. This is an entrant's sole and exclusive remedy.

Stat. Auth.: ORS 461 & OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.220, 461.230 & 461.250
Hist.: LOTT 5-2011(Temp), f. & cert. ef. 9-2-11 thru 1-29-12; LOTT 7-2011, f. 11-21-11, cert. ef. 12-1-11; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-052-0060
Winner Notification and Claiming of Prizes

(1) Second Chance Prize Notification: If the entry is valid, the Lottery will notify the person who submitted the winning entry ("the winner") in a second chance drawing by e-mail. The Lottery may also notify the winner by telephone or by mailing a certified letter through the U.S. Postal Service. The effective date of notification is the date the initial e-mail notification is sent by the Lottery as noted electronically within the Lottery's information processing system.

(2) Time Limits for Claiming Prize: A winner of a second chance drawing has 60 calendar days from the date of the e-mail notification in which to claim the prize. A prize must be claimed by 5:00 p.m. on the last date to claim a prize and if not claimed by that date is an unclaimed prize. If the final date of the claim period falls on a day when the Oregon Lottery Headquarters is not open to the general public, such as a weekend, Lottery holiday, or furlough closure day, the claim period shall be extended until 5:00 p.m. on the next day the Oregon Lottery Headquarters is open to the general public.

(3) Forfeiture of Prize: If the winner of a second chance drawing is determined by the Lottery to be ineligible, the entry is invalid, or the winner fails to claim the prize within 60 calendar days as provided in section (2) of this rule, the prize is treated as an unclaimed prize and the winner forfeits the prize.

(4) Winner Claim Forms: To claim a prize in a second chance drawing, the winner must submit a winner claim form to the Lottery. To be valid, the winner claim form must contain the required information, such as name, address, signature or identifying mark, social security number (if applicable), and a valid reference number. Only the person who submitted the entry may claim the prize (the winner). A second chance drawing prize may not be claimed by multiple owners. A valid winner claim form must be received by the Lottery within the applicable time period for claiming a prize. An invalid winner claim form will not be accepted by the Lottery and will be returned to the claimant. The winner may resubmit a valid claim form as long as the time for claiming the prize has not expired.

(a) Electronic Claim Form: The Lottery may require that the winner submit an electronic winner claim form through the Internet. The electronic winner claim form is received by the Lottery when the form enters the Lottery's information processing system in a retrievable form. The electronic winner claim form will be deemed received at the time and date noted electronically by the Lottery's information processing system. An electronic winner claim form must include the winner's electronic signature that meets the requirements specified by the Lottery on the instructions for the winner claim form.

(b) Paper Claim Form: Unless specified otherwise, the Lottery may permit a winner to submit a paper winner claim form. The paper winner claim form is deemed received by fax to (503) 540-1001 or upon physical delivery to the Oregon State Lottery, Player Services Office, 500 Airport Road SE, Salem, Oregon 97301, either in person, or by delivery service, or through the U.S. mail to the Oregon State Lottery, P.O. Box 14515, Salem, Oregon 97309. The winner claim form must be received by the Lottery during the Lottery's business hours, Monday through Friday, 8:00 a.m. to 5:00 p.m. PST, excluding holidays and furlough closure days.

(5) Verification of Identity: The Lottery may require the winner to present valid proof of identity to confirm that the winner is the registered member who submitted the second chance drawing entry. If the Lottery is unable to confirm the person claiming the prize is the registered member, the person is ineligible to receive a prize.

(6) Delivery of Prize: The Lottery may require the winner of a second chance drawing prize to claim the winner's prize at the Oregon State Lottery Headquarters, 500 Airport Road SE, Salem, Oregon 97301, or the Lottery may mail or otherwise deliver the prize to the winner's address if it is within the United States.

(7) Taxes and Fees: Unless otherwise stated by the Lottery in the terms and conditions for a particular second chance drawing, all taxes and fees are the responsibility of the winner claiming the prize.

Stat. Auth.: ORS 461 & OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.220, 461.230 & 461.250
Hist.: LOTT 5-2011(Temp), f. & cert. ef. 9-2-11 thru 1-29-12; LOTT 7-2011, f. 11-21-11, cert. ef. 12-1-11; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-052-0070
Governing Law

(1) Compliance with Law and Terms and Conditions: By entering a Lottery second chance drawing, a person agrees to abide by and comply with Oregon law, including the statutes and administrative rules governing Lottery second chance drawings, and any additional terms and conditions and entry requirements for a second chance drawing as posted by the Lottery, which are in effect, and which may be amended from time to time.

(2) Decisions of the Director: The decisions of the Lottery Director, including, but not limited to, the amount or nature of a prize, the validity of an entry, whether an entry is a winner, whether it was submitted in error, and whether an entrant has won a prize, are final.

Stat. Auth.: ORS 461 & OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.220, 461.230 & 461.250
Hist.: LOTT 5-2011(Temp), f. & cert. ef. 9-2-11 thru 1-29-12; LOTT 7-2011, f. 11-21-11, cert. ef. 12-1-11; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

177-070-0005
Definitions

For the purposes of division 70, the following definitions apply except as otherwise specifically provided in OAR chapter 177 or unless the context requires otherwise:

(1) "Drawing" means the procedure whereby the Lottery, or a drawing agent, selects the winning combination in accordance with the rules of the game.

(2) "Drawing agent" means a Lottery vendor or other designee who, subject to the approval of the Director, is designated by the Assistant Director of Security to conduct drawings on behalf of the Lottery.

(3) "Draw game" means a lottery game, other than Video Lottery^{SM} games, in which through a Draw game terminal, the player or the Draw game terminal selects a combination of numbers, events or symbols, the player selects the type of game and amount of play, and the drawing date(s), or the player purchases a Lottery Raffle ticket. Draw games are those Lottery games specified in OAR 177-010-0003(24)(b) through (m) and any other Lottery game designated by the Lottery Commission as a Draw game. Unless the context or a specially applicable definition indicates otherwise, any reference to an "On Line game" in OAR chapter 177, a Lottery retailer contract, or Lottery form in effect or in use on or after the effective date of this rule shall be deemed to refer to a "Draw game" as defined in this section.

(4) "Draw game retailer" means a person or business authorized by the Lottery to sell Draw game tickets.

(5) "Draw game terminal (DGT)" means the computer hardware by which:

(a) A Draw game retailer or player enters the combination of numbers, events, or symbols selected by the player, or

(b) A combination of numbers, events, or symbols is randomly selected for the player, or

(c) A Lottery Raffle ticket is issued; and

(d) Draw game tickets are generated and claims are validated.

(6) "Draw game ticket" means a computer-generated ticket issued by a Draw game terminal to a player as a receipt for the combination a player or the terminal has selected, or a Lottery Raffle ticket. This ticket is the only acceptable evidence of the combination of numbers, events, or symbols selected, or of the unique sequential numbers on a Lottery Raffle game ticket.

(7) "Play slip" means a card used in selecting and marking a player's game plays which may then be inserted into a terminal's play slip reader.

(8) "Validation" means the process of determining whether a Draw game ticket presented for payment is a winning ticket.

(9) "Winning combination" means the one or more numbers or symbols randomly selected by the Lottery in a drawing.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.010
Hist.: SLC 11-1985(Temp), f. & ef. 10-24-85; SLC 5-1986, f. & ef. 3-5-86; LC 3-1992, f. & cert. ef. 4-27-92; LC 6-1993, f. & cert. ef. 7-2-93; LOTT 15-2002(Temp), f. 9-6-02, cert. ef. 9-9-02 thru 3-6-03; LOTT 26-2002, f. & cert. ef. 11-25-02; LOTT 6-2009, f. 9-28-09, cert. ef. 10-1-09; LOTT 6-2010, f. 3-18-10, cert. ef. 3-21-10; LOTT 1-2013(Temp), f. & cert. ef. 2-1-13 thru 7-27-13; LOTT 2-2013, f. 6-24-13, cert. ef. 7-1-13

Oregon State Marine Board
Chapter 250

Rule Caption: Establish slow-no-wake zone around the Portland-Milwaukie Light Rail Bridge construction project.
Adm. Order No.: OSMB 4-2013
Filed with Sec. of State: 6-28-2013
Certified to be Effective: 6-28-13
Notice Publication Date: 6-1-2013
Rules Amended: 250-020-0280
Rules Repealed: 250-020-0280(T)
Subject: This rule will establish a slow-no-wake zone 500 feet upstream and downstream of the Portland-Milwaukie Light Rail Bridge construction zone.
Rules Coordinator: June LeTarte—(503) 378-2617

250-020-0280
Boat Operations in Multnomah County

(1) No person shall operate a boat in excess of 5 MPH:

(a) In North Portland Harbor (Oregon Slough):

(A) From the east end of North Portland Harbor (Oregon Slough) to a point 800 yards west of the Burlington Northern Railroad Bridge, as marked;

(B) Within 200 feet of a launching ramp, moorage or houseboat from the east end of North Portland Harbor (Oregon Slough) eastward along the south shore to the Lower Airport wing dike.

(b) Within 300 feet of the entrance to and in Rooster Rock boat channel;

(c) Within 200 feet of west shore, as buoyed, between the southern boundary of Willamette Park Launch Ramp and the northern boundary of the Willamette Sailing Club;

(d) Within Hayden Bay. The Bay is considered to be all waters south and west of a line 200 feet north of the Northeast point of Hayden Island and 200 feet north of the Northwest point of Tomahawk Island as marked;

(e) Within 200 feet of the Oregon Yacht Club floating home moorage as buoyed (a distance of approximately 1,5000 feet);

(f) Within 200 feet of houseboat moorages in the Government Island South Channel;

(g) No person shall operate a boat in excess of a maximum 5 MPH, "Slow — No Wake" speed on the Columbia River south of the buoys along the northern shore of Government Island in the waters adjacent to the I-205 Bridge, commonly referred to as Commodore's Cove, as marked;

(h) Within 100 feet of the Landing Boat Club at RM 15, Willamette River.

(2) No person shall operate a watercraft in excess of slow-no-wake in:

(a) The Ross Island Lagoon; and

(b) The Holgate Channel from a line extending northeast from the north side of the Ross Island Lagoon mouth to the east side of the channel, and to a line extending from the southern (upstream) tip of Ross Island due south to the Oregon Yacht Club.

(c) This restriction does not apply to:

(A) Federally documented commercial vessels required to be inspected under Federal law, including those operated for sand and gravel operations, with the exception of passenger vessels of less than 100 gross tons, which are subject to the restriction;

(B) Safety launches while accompanying an organized rowing or paddling program, club or school.

(3) No person shall operate a boat in excess of a maximum 5 MPH, "Slow — No Wake" speed on the Columbia River within 300 feet of shore between the Big Eddy Wing dike and the wing dike east of the entrance to the Chinook Landing boat Basin and within the Chinook Landing Boat Basin, as marked.

(4) A "pass-through" zone is established in the south channel of the Columbia River, adjacent to McGuire Island between the east end of Big Eddy Marina and the west end of McGuire Point Marina as marked.

(a) No person shall operate a motorboat pulling a water skier or towed device in this zone.

(b) No person shall operate a personal watercraft, as defined in OAR 250-021-0020, in continuous operation above 5 MPH in this area, except to transit directly through this zone.

(c) No person shall operate any motorboat in excess of slow-no wake maximum 5 MPH speed within 200 feet of any houseboat moorage within the "pass-through" zone.

(5) No person shall operate a boat in excess of 3 MPH in Rooster Rock Boat Basin.

(6) The following locations are designated racing motorboat testing areas:

(a) On the Willamette River in Swan Island Lagoon. Testing is limited to the hours of 3–6 p.m. on Thursdays, Fridays, and Saturdays;

(b) On the Columbia River between the county launching ramp at 43rd Street and Buoy #18 (NOS Chart #18531). Testing is limited to the hours of 8 am–12 noon, Tuesday through Friday.

(7) No person shall operate a motorboat on Benson Lake.

(8) No person shall operate a boat for any reason within any restricted area at any time without first obtaining permission from the District Engineer, Corps of Engineers, U.S. Army, or his duly authorized representative.

(9) At Bonneville Dam.

(a) The Waters restricted to only Government vessels are described as all waters of the Columbia River and Bradford Slough within 1,000 feet above and 2,000 feet below the powerhouse. The restricted areas will be designated by signs;

(b) No person shall operate a boat, including a commercial recreational tour boat subject to inspection and licensing by the U.S. Coast Guard, within the Boating Restricted Zone located below Bonneville lock and dam bounded by a line commencing from the westernmost tip of Robins Island on the Oregon side of the Columbia River and running at a South 65 degrees West direction a distance of approximately 2100 feet to a point 50 feet upstream of the Hamilton Island Boat Ramp on the Washington side of the Columbia River, as marked.

(10) No person shall operate or anchor a boat in the following described zone in Oregon Slough (North Portland Harbor):

(a) Commencing at the northwesterly corner of that tract of land described in a Bargain and Sale Deed to RHODIA, Inc., recorded as Document No. 98028586, Multnomah County Deed Records; Thence, along the northeasterly line of said tract, S 47°46' E, 513.54 feet to the northwest corner of the Alexander Brown Donation Land Claim; Thence, along the north line of said Claim S 48°30' E, 764.51 feet to the POINT OF BEGINNING of the SITE AREA being described herein; Thence, N 29°58'25" E, 133.84 feet; Thence, S 62°44'22" E, 461.47 feet; Thence, S 29°58'25" W, 227.76 feet to the northeasterly line of said tract; Thence, along said northeasterly line, N 61°15' W, 60.85 feet; Thence, along said northeasterly line, N 52°30' W, 115.5 feet; Thence, along said northeasterly line, N 48°30' W, 291.49 feet to the POINT OF BEGINNING as marked.

(b) This area of land contains 2.0 acres (87,008 sq. Ft.), more or less.

(c) The intent of this description is to describe a line that surrounds the limits of the sediment cap location, plus a buffer zone.

(d) Bearings based on Document No. 98028586, Multnomah County Deed Records.

(11) No person shall anchor a boat at approximately River Mile 7 of the Willamette River in Multnomah County described in Department of State Lands Easement No. 31530-EA, Exhibit A — Legal Description — Permanent Easement.

(12) No person shall operate a boat in the Willamette River:

(a) In the area beneath the temporary construction bridges or lifting cranes used for construction of the Portland-Milwaukie Light Rail Bridge near river mile 13.8.

(b) In excess of 5 MPH Slow-No-Wake as marked 500 feet upriver and 500 feet downriver from the centerline of the bridge construction project.

(c) In the area of the Sellwood Bridge Construction Project, from approximately 375 feet from the west river bank and 200 feet upstream and downstream of the bridge measured at the bridge centerline; and about 420 feet from the east river bank and about 200 feet upstream and downstream of the bridge measured at the bridge centerline.

(d) In excess of 5 mph Slow-No-Wake as marked 500 feet upriver and 500 feet downriver from the centerline of the Sellwood Bridge construction project.

(13) The Sellwood Bridge Construction rule provisions will sunset at the completion of construction in December 2015

(14) The Portland-Milwaukie Light Rail Bridge rule provisions will sunset upon removal of the temporary construction bridges or no later than September 30, 2014.

Stat. Auth.: ORS 830.110
Stats. Implemented: ORS 830.175
Hist.: MB 23, f. 9-24-63; MB 26, f. 7-20-64; MB 51, f. 5-3-73, ef. 5-15-73; MB 61, f. 7-26-74, ef. 7-26-74(Temp) & 8-25-74(Perm); Renumbered from 250-020-0155; MB 10-1982, f. 10-13-82, ef. 10-15-82; MB 12-1982, f. 12-29-82, ef. 12-31-82; MB 6-1983, f. 9-28-83, ef. 10-3-83; MB 17-1984, f. & ef. 12-3-84; MB 6-1985, f. & ef. 2-5-85; MB 10-1985, f. & ef. 4-24-85; MB 15-1985, f. 10-18-85, ef. 10-21-85; MB 20-1987, f. 11-4-87, ef. 11-15-87; MB 5-1990, f. & cert. ef. 7-19-90; MB 11-1992, f. & cert. ef. 9-16-92; MB 2-1993, f. & cert. ef. 2-3-93; MB 13-1996, f. & cert. ef. 12-4-96; OSMB 7-1998(Temp), f. & cert. ef. 5-19-98 thru 11-15-98; OSMB 7-1999, f. & cert. ef. 6-18-99; OSMB 2-2005, f. & cert. ef. 1-20-05; OSMB

8-2006, f. & cert. ef. 10-12-06; OSMB 3-2009, f. 10-21-09, cert. ef. 1-1-10; OSMB 4-2011, f. 3-7-11, cert. ef. 5-25-11; OSMB 8-2011, f. 4-25-11, cert. ef. 6-1-11; OSMB 9-2011(Temp), f. 5-13-11, cert. ef. 6-15-11 thru 10-31-11; Administrative correction, 11-18-11; OSMB 16-2011(Temp), f. 11-22-11, cert. ef. 12-1-11 thru 5-28-12; OSMB 17-2011(Temp), f. 12-22-11, cert. ef. 1-1-12 thru 5-28-12; OSMB 5-2012, f. & cert. ef. 4-20-12; OSMB 3-2013(Temp), f. & cert. ef. 5-8-13 thru 10-31-13; OSMB 4-2013, f. & cert. ef. 6-28-13

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Rule Caption: Establish slow-no-wake in front of the South Greenway construction project on the Willamette River.
Adm. Order No.: OSMB 5-2013(Temp)
Filed with Sec. of State: 7-1-2013
Certified to be Effective: 7-1-13 thru 10-31-13
Notice Publication Date:
Rules Amended: 250-020-0280
Subject: This rule implements a slow-no-wake zone in the Willamette River in the marked area immediately upstream of the Zidell barge launch across from the north tip of Ross Island. The area extends south approximately 1200' to a point adjacent to SW Gains Street, and extends approximately 200' from the west shore eastward into the river.
Rules Coordinator: June LeTarte—(503) 378-2617

250-020-0280
Boat Operations in Multnomah County

(1) No person shall operate a boat in excess of 5 MPH:

(a) In North Portland Harbor (Oregon Slough):

(A) From the east end of North Portland Harbor (Oregon Slough) to a point 800 yards west of the Burlington Northern Railroad Bridge, as marked;

(B) Within 200 feet of a launching ramp, moorage or houseboat from the east end of North Portland Harbor (Oregon Slough) eastward along the south shore to the Lower Airport wing dike.

(b) Within 300 feet of the entrance to and in Rooster Rock boat channel;

(c) Within 200 feet of west shore, as buoyed, between the southern boundary of Willamette Park Launch Ramp and the northern boundary of the Willamette Sailing Club;

(d) Within Hayden Bay. The Bay is considered to be all waters south and west of a line 200 feet north of the Northeast point of Hayden Island and 200 feet north of the Northwest point of Tomahawk Island as marked;

(e) Within 200 feet of the Oregon Yacht Club floating home moorage as buoyed (a distance of approximately 1,5000 feet);

(f) Within 200 feet of houseboat moorages in the Government Island South Channel;

(g) No person shall operate a boat in excess of a maximum 5 MPH, "Slow — No Wake" speed on the Columbia River south of the buoys along the northern shore of Government Island in the waters adjacent to the I-205 Bridge, commonly referred to as Commodore's Cove, as marked;

(h) Within 100 feet of the Landing Boat Club at RM 15, Willamette River.

(2) No person shall operate a watercraft in excess of slow-no-wake in:

(a) The Ross Island Lagoon; and

(b) The Holgate Channel from a line extending northeast from the north side of the Ross Island Lagoon mouth to the east side of the channel, and to a line extending from the southern (upstream) tip of Ross Island due south to the Oregon Yacht Club.

(c) This restriction does not apply to:

(A) Federally documented commercial vessels required to be inspected under Federal law, including those operated for sand and gravel operations, with the exception of passenger vessels of less than 100 gross tons, which are subject to the restriction;

(B) Safety launches while accompanying an organized rowing or paddling program, club or school.

(3) No person shall operate a boat in excess of a maximum 5 MPH, "Slow — No Wake" speed on the Columbia River within 300 feet of shore between the Big Eddy Wing dike and the wing dike east of the entrance to the Chinook Landing boat Basin and within the Chinook Landing Boat Basin, as marked.

(4) A "pass-through" zone is established in the south channel of the Columbia River, adjacent to McGuire Island between the east end of Big Eddy Marina and the west end of McGuire Point Marina as marked.

(a) No person shall operate a motorboat pulling a water skier or towed device in this zone.

(b) No person shall operate a personal watercraft, as defined in OAR 250-021-0020, in continuous operation above 5 MPH in this area, except to transit directly through this zone.

(c) No person shall operate any motorboat in excess of slow-no wake maximum 5 MPH speed within 200 feet of any houseboat moorage within the "pass-through" zone.

(5) No person shall operate a boat in excess of 3 MPH in Rooster Rock Boat Basin.

(6) The following locations are designated racing motorboat testing areas:

(a) On the Willamette River in Swan Island Lagoon. Testing is limited to the hours of 3–6 p.m. on Thursdays, Fridays, and Saturdays;

(b) On the Columbia River between the county launching ramp at 43rd Street and Buoy #18 (NOS Chart #18531). Testing is limited to the hours of 8 am–12 noon, Tuesday through Friday.

(7) No person shall operate a motorboat on Benson Lake.

(8) No person shall operate a boat for any reason within any restricted area at any time without first obtaining permission from the District Engineer, Corps of Engineers, U.S. Army, or his duly authorized representative.

(9) At Bonneville Dam.

(a) The Waters restricted to only Government vessels are described as all waters of the Columbia River and Bradford Slough within 1,000 feet above and 2,000 feet below the powerhouse. The restricted areas will be designated by signs;

(b) No person shall operate a boat, including a commercial recreational tour boat subject to inspection and licensing by the U.S. Coast Guard, within the Boating Restricted Zone located below Bonneville lock and dam bounded by a line commencing from the westernmost tip of Robins Island on the Oregon side of the Columbia River and running at a South 65 degrees West direction a distance of approximately 2100 feet to a point 50 feet upstream of the Hamilton Island Boat Ramp on the Washington side of the Columbia River, as marked.

(10) No person shall operate or anchor a boat in the following described zone in Oregon Slough (North Portland Harbor):

(a) Commencing at the northwesterly corner of that tract of land described in a Bargain and Sale Deed to RHODIA, Inc., recorded as Document No. 98028586, Multnomah County Deed Records; Thence, along the northeasterly line of said tract, S 47°46' E, 513.54 feet to the northwest corner of the Alexander Brown Donation Land Claim; Thence, along the north line of said Claim S 48°30' E, 764.51 feet to the POINT OF BEGINNING of the SITE AREA being described herein; Thence, N 29°58'25" E, 133.84 feet; Thence, S 62°44'22" E, 461.47 feet; Thence, S 29°58'25" W, 227.76 feet to the northeasterly line of said tract; Thence, along said northeasterly line, N 61°15' W, 60.85 feet; Thence, along said northeasterly line, N 52°30' W, 115.5 feet; Thence, along said northeasterly line, N 48°30' W, 291.49 feet to the POINT OF BEGINNING as marked.

(b) This area of land contains 2.0 acres (87,008 sq. Ft.), more or less.

(c) The intent of this description is to describe a line that surrounds the limits of the sediment cap location, plus a buffer zone.

(d) Bearings based on Document No. 98028586, Multnomah County Deed Records.

(11) No person shall anchor a boat at approximately River Mile 7 of the Willamette River in Multnomah County described in Department of State Lands Easement No. 31530-EA, Exhibit A — Legal Description — Permanent Easement.

(12) No person shall operate a boat in the Willamette River:

(a) In the area beneath the temporary construction bridges or lifting cranes used for construction of the Portland-Milwaukie Light Rail Bridge near river mile 13.8.

(b) In excess of 5 MPH Slow-No-Wake as marked 500 feet upriver and 500 feet downriver from the centerline of the bridge construction project.

(c) In the area of the Sellwood Bridge Construction Project, from approximately 375 feet from the west river bank and 200 feet upstream and downstream of the bridge measured at the bridge centerline; and about 420 feet from the east river bank and about 200 feet upstream and downstream of the bridge measured at the bridge centerline.

(d) In excess of 5 mph Slow-No-Wake as marked 500 feet upriver and 500 feet downriver from the centerline of the Sellwood Bridge construction project.

(e) In excess of 5 mph slow-no-wake from July 1–October 31, 2013, in the marked area immediately upstream of the Zidell barge launch across from the north tip of Ross Island. The area extends south approximately

1200' to a point adjacent to SW Gains Street and extends approximately 200' from the west shore eastward into the river.

(13) The Sellwood Bridge Construction rule provisions will sunset at the completion of construction in December 2015

(14) The Portland-Milwaukie Light Rail Bridge rule provisions will sunset upon removal of the temporary construction bridges or no later than September 30, 2014.

Stat. Auth.: ORS 830.110
Stats. Implemented: ORS 830.175
Hist.: MB 23, f. 9-24-63; MB 26, f. 7-20-64; MB 51, f. 5-3-73, ef. 5-15-73; MB 61, f. 7-26-74, ef. 7-26-74(Temp) & 8-25-74(Perm); Renumbered from 250-020-0155; MB 10-1982, f. 10-13-82, ef. 10-15-82; MB 12-1982, f. 12-29-82, ef. 12-31-82; MB 6-1983, f. 9-28-83, ef. 10-3-83; MB 17-1984, f. & ef. 12-3-84; MB 6-1985, f. & ef. 2-5-85; MB 10-1985, f. & ef. 4-24-85; MB 15-1985, f. 10-18-85, ef. 10-21-85; MB 20-1987, f. 11-4-87, ef. 11-15-87; MB 5-1990, f. & cert. ef. 7-19-90; MB 11-1992, f. & cert. ef. 9-16-92; MB 2-1993, f. & cert. ef. 2-3-93; MB 13-1996, f. & cert. ef. 12-4-96; OSMB 7-1998(Temp), f. & cert. ef. 5-19-98 thru 11-15-98; OSMB 7-1999, f. & cert. ef. 6-18-99; OSMB 2-2005, f. & cert. ef. 1-20-05; OSMB 8-2006, f. & cert. ef. 10-12-06; OSMB 3-2009, f. 10-21-09, cert. ef. 1-1-10; OSMB 4-2011, f. 3-7-11, cert. ef. 5-25-11; OSMB 8-2011, f. 4-25-11, cert. ef. 6-1-11; OSMB 9-2011(Temp), f. 5-13-11, cert. ef. 6-15-11 thru 10-31-11; Administrative correction, 11-18-11; OSMB 16-2011(Temp), f. 11-22-11, cert. ef. 12-1-11 thru 5-28-12; OSMB 17-2011(Temp), f. 12-22-11, cert. ef. 1-1-12 thru 5-28-12; OSMB 5-2012, f. & cert. ef. 4-20-12; OSMB 3-2013(Temp), f. & cert. ef. 5-8-13 thru 10-31-13; OSMB 4-2013, f. & cert. ef. 6-28-13; OSMB 5-2013(Temp), f. & cert. ef. 7-1-13 thru 10-31-13

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Oregon University System, Southern Oregon University
Chapter 573

Rule Caption: Code of Student Conduct
Adm. Order No.: SOU 2-2013
Filed with Sec. of State: 6-20-2013
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Subject: Southern Oregon University's published expectations for the conduct of its students, as well as processes and procedures for adjudicating matters in which students are alleged to have violated prohibited student conduct. Revisions are made to this document on an annual basis to bring it into compliance with legislation, organizational change, and nationally-recognized practices.
Rules Coordinator: Treasa Sprague—(541) 552-6319

573-076-0040
Oversight and Administration

(1) When it appears that a student has violated one or more University policies, the University intervenes with a process designed to resolve the issue and ensure that future problems do not arise. The Office of Student Affairs coordinates the procedures associated with response to student conduct issues. The responsibilities of the office include:

(a) Receipt of information about alleged policy violations (typically from Campus Public Safety reports, Residence Hall incident reports, and/or reports from other students)

(b) Determination of the policies that appear to have been violated.

(c) Interviewing and advising parties involved in student conduct proceedings.

(d) Training and advising conduct officers and conduct boards.

(e) Conducting hearings.

(f) Reviewing the decisions of conduct boards.

(g) Maintenance of all student conduct records.

(h) Development of procedures for conflict resolution.

(i) Monitoring of educational sanctions.

(j) Collection and dissemination of research and analysis concerning student conduct.

(2) Director of Student Development and Support Services (Director) or designee determines who will hear each allegation of student misconduct.

(3) The Director may designate an arbiter for disputes within the student community which do not involve a violation of University policy. All parties must agree to arbitration, and to be bound by the decision with no opportunity to appeal.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Hist.: SOU 2-2009, f. 8-5-09 cert. ef. 8-7-09; SOU 2-2013, f. & cert. ef. 6-20-13

573-076-0050
Conduct Officers and Conduct Boards

In matters of alleged violations of this code, the Director or designee will determine the appropriate forum for hearings proceedings outlined in this code. The University maintains an active pool of faculty, administrators, and specially trained students for the purpose of hearing and resolving student conduct allegations. Hearings or other proceedings outlined in this Code may be held before the following individuals or boards:

(1) Peer Review Board: Generally consisting of no fewer than three trained SOU students, a peer review board will primarily hear allegations involving disruption of community standards, and may also act as a mediating body for disputes that occur outside the scope of this code.

(2) University Review Board: Consisting of at least one faculty member, one administrator, and one student. A University review board will primarily hear allegations that involve faculty or staff members as victims, or other allegations deemed appropriate by the Director or designee.

(3) Academic Misconduct Review Board: Consisting of at least two faculty and two trained students. An academic misconduct review board will hear allegations of academic misconduct as outlined in the Prohibited Conduct section of this code.

(4) Conduct Conference: The Director or designee may hear allegations in a one-to-one format where appropriate.

(5) Sexual Misconduct Review Board: Consisting of specially trained faculty and administrators. The Sexual Misconduct Review Board will hear all allegations of sexual misconduct as outlined in the Prohibited Conduct section of this code.

(6) At the discretion of the Director or designee, cases involving assault, intimidation, or other matters posing an immediate threat to the campus community, may be heard by the Director or designee, independent of conduct board action.

(7) Student members of any conduct board who are charged with any violation of this Code or with a criminal offense may be suspended from their conduct positions by the Director or designee until a final resolution of the situation is obtained. Students found responsible for any such violation or offense may be disqualified from any further participation in the University conduct system by the Director or designee.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Hist.: SOU 2-2009, f. 8-5-09 cert. ef. 8-7-09; SOU 3-2011, f. & cert. ef. 6-13-11; SOU 2-2013, f. & cert. ef. 6-20-13

573-076-0060
Conduct Referrals and Hearing Procedures

(1) Any person may refer a student or a student group or organization suspected of violating University policy to the Office of Student Affairs. Persons making such referrals are required to provide information pertinent to the situation and will normally be expected to provide an incident report and written statement, and/or appear at a hearing as the complainant. The hearing format for resolution will be selected at the discretion of the Director or designee.

(2) The Director or designee may conduct an investigation (or request conduct of an investigation by other University officials) to determine if the allegations have merit and/or if they can be disposed of administratively by mutual consent of the parties involved on a basis acceptable to the Director or designee. Such disposition shall be final and there shall be no subsequent proceedings. If the charges cannot be disposed of by mutual consent, the Director or designee will proceed with a hearing.

(3) All allegations of misconduct are presented to the accused student in written form. The notification includes the date or date range, location, and description of the prohibited conduct relevant to the alleged violation. A time is set for a hearing, not less than three (3) calendar days and not more than fifteen (15) calendar days after the student has been notified. Minimum and maximum time limits for scheduling of hearings may be extended at the discretion of the Director or designee based on the academic calendar or at the written request of the accused student.

(4) Hearings are conducted according to the following guidelines:

(a) Hearings are conducted in private, unless both the accused student(s) and the complainant(s) agree to an open hearing.

(b) Admission of any person to the hearing is at the discretion of the Director or designee.

(c) In hearings involving more than one accused student, the Director or designee may permit the hearings concerning each student to be conducted separately.

(d) The complainant and the accused may be accompanied by an advisor. The complainant and/or the accused is responsible for presenting his or

her own information. Comments from advisors may be requested from the Director or Designee facilitating the hearing.

(e) The complainant, the accused, and the conduct officer/board have the privilege of presenting witnesses, subject to questioning by the conduct officer/board.

(f) Pertinent records, exhibits, and written statements may be accepted for consideration by a conduct officer/board at the discretion of the Director or designee.

(g) All procedural questions are subject to the final decision of the Director or designee.

(h) After the hearing, the accused student is dismissed and the conduct officer or board (by majority vote) determines whether the student is responsible for each alleged policy violation.

(i) The conduct officer/board's determination is made on the basis of whether it is "more likely than not" that the accused student violated the policy(ies).

(j) Not more than ten (10) working days following the hearing, the accused student is notified in writing of the decision and its rationale, including any sanction(s) imposed, and the opportunity to appeal the decision.

(k) There is a record of all hearings before a hearing board, consisting of an audio recording and all written documentation including notes taken during the hearing. The record is the property of the University and is maintained in the Office of Student Affairs.

(l) Except in the case of a student accused of violating the "failure to comply with directives" policy by not appearing before a conduct board or University official, no student may be found to have violated the policy(ies) in question solely because the student failed to appear. In all hearings, the information in support of the allegations is presented and considered. Final decisions are based on the information available.

(5) Principles governing Honor Board decisions of alleged academic misconduct are as follows:

(a) Academic penalties (grades) are imposed only by faculty members (course instructor).

(b) Because academic misconduct is a policy violation, disciplinary penalties (probation, suspension, or dismissal) may be imposed only by the Director or designee, upon recommendation from the Academic Misconduct Review Board, or when the Board cannot meet, upon recommendation from the faculty member.

(6) Sexual Misconduct Review Board hearings are conducted in accordance with guidelines established in the Sexual Misconduct Policy.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Hist.: SOU 2-2009, f. 8-5-09 cert. ef. 8-7-09; SOU 3-2011, f. & cert. ef. 6-13-11; SOU 2-2013, f. & cert. ef. 6-20-13

573-076-0070
Sanctions

(1) A disciplinary sanction is an educational tool designed to send a clear message regarding violation of University policy. Sanctions relate to the nature of the violation, with stronger sanctions imposed for more aggravated or repeated misconduct. Sanctions of probation, suspension, and dismissal require the approval of the Director or designee.

(2) The following sanctions may be imposed when a student is found responsible for policy violation(s):

(a) Warning: A notice in writing to the student that the student is violating or has violated University policy.

(b) Loss of Privileges: Denial of specified privileges for a designated period of time.

(c) Fines: Previously established and published fines may be charged to a student's account.

(d) Restitution: Compensation for loss, damage, or injury. This may take the form of appropriate service and/or monetary or material replacement.

(e) Discretionary Sanctions: Work assignments, research, apology letters, service to the University, or other related discretionary assignments.

(f) Educational classes to be paid by fee assessed to violator. Fee may be paid directly or through community restitution.

(g) Conditional Disciplinary Probation: A written reprimand which places the student's participation in University activities in a provisional status. Probation may exclude the student from participation in co-curricular activities in which the student represents the University (e.g. varsity athletics and club sports, elected student office, debate, musical and dramatic groups). Probation may include mandatory counseling and includes the probability of more severe disciplinary sanctions if the student further violates University regulation(s) during the probationary period.

(h) Residence Hall Suspension: Separation of the student from the residence halls for a stated period of time, after which the student is eligible to return. Because the University maintains a one year residency requirement, a residence hall suspension may result in a suspension from the University, if the student has not completed the one year residency requirement. Conditions for readmission may be specified. The student may be issued a written trespass notice from one or more residence halls for the duration of the suspension.

(i) Residence Hall Expulsion: Permanent separation of the student from the residence halls. The student will be issued a written trespass notice from all residence halls at the time of the expulsion.

(j) Eviction from University Housing: Removal from any University owned or operated housing other than the residence halls. The student will be issued a written trespass notice from all University housing at the time of the eviction.

(k) Unconditional Probation: Immediate invocation of University suspension if additional violation(s) of University policies occur during a specified period of time. Unconditional Probation also includes the provisions of a disciplinary probation.

(l) University Suspension: Separation of the student from the University for a specific period of time after which the student is eligible to return. Conditions for readmission may be specified. At the discretion of the Director or designee, a University trespass order is in effect for the period of the suspension. A suspension may be deferred to the end of a term at the discretion of the Director or designee.

(m) University Dismissal: Permanent separation of the student from the University.

(3) The following sanctions may be imposed upon groups or organizations:

(a) Those sanctions listed above.

(b) Deactivation—Loss of all privileges, including University recognition, for a specified period of time.

(4) Interim Suspension—In certain circumstances, the Director or designee may impose a University or residence hall suspension prior to the hearing.

(a) Interim suspension may be imposed only:

(A) To ensure the comfort, safety, and well being of members of the University community or preservation of University property and/or;

(B) To ensure the student's own physical or emotional safety and well being and/or;

(C) If the student poses a definite threat of disruption of or interference with the normal operations of the University.

(b) During the interim suspension, the student is denied access to the campus (including classes) and all other University activities or privileges for which the student might otherwise be eligible, as the Director or designee may determine to be appropriate.

(5) More than one of the sanctions listed above may be imposed for any single violation.

(6) Other than University dismissal, disciplinary sanctions are not made part of the student's permanent academic record, but are part of the student's confidential disciplinary record.

(7) Where sanctions involve the separation of the responsible student from University housing, the student is accountable for all financial penalties or other conditions as outlined in the residential housing contract.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Hist.: SOU 2-2009, f. 8-5-09 cert. ef. 8-7-09; SOU 3-2011, f. & cert. ef. 6-13-11; SOU 2-2013, f. & cert. ef. 6-20-13

573-076-0080
Appeals

(1) A decision may be appealed within ten (10) working days of the date of the decision letter to the Associate Provost. Such appeals must be in writing and must be delivered by mail or email.

(2) An appeal is limited to one or more of the following purposes:

(a) To determine whether the original hearing was conducted fairly in light of the allegations and information presented and in conformity with the procedures outlined in this Code.

(b) To determine whether the decision reached regarding the accused student was based on substantial information, that is, whether the facts were sufficient to establish that a violation of University policy occurred under the "more likely than not" standard.

(c) To determine whether the sanction(s) imposed were appropriate for the violation(s) which the student was found to have committed.

(d) To consider new information, sufficient to alter a decision, or other relevant facts not brought out in the original hearing, because such

information and/or facts were not known to the person appealing at the time of the original hearing.

(3) If an appeal is granted, this written decision will be communicated to the original conduct officer/ board for action, if appropriate.

(4) In cases of sexual misconduct, the complainant or victim may appeal the decision and sanctions according to the standard outlined above.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Hist.: SOU 2-2009, f. 8-5-09 cert. ef. 8-7-09; SOU 3-2011, f. & cert. ef. 6-13-11; SOU 2-2013, f. & cert. ef. 6-20-13

573-076-0090
Student Groups and Organizations

(1) Student groups and organizations may be charged with violations of University policy.

(2) A student group or organization and its officers may be held collectively or individually responsible when violations of policy by those associated with the group or organization have received the tacit or overt consent or encouragement of the group or organization or of the group's or organization's leaders, officers, or spokespersons.

(3) The student officers or leaders or any identifiable spokespersons for a student group or organization may be directed by the Director or designee to take action to prevent or end violations by the group or organization. Failure to make reasonable efforts to comply with any resulting directives shall be considered a violation of University policy, both by the officers, leaders, or spokespersons for the group or organization and by the group or organization itself.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Hist.: SOU 2-2009, f. 8-5-09 cert. ef. 8-7-09; SOU 2-2013, f. & cert. ef. 6-20-13

573-076-0100
Parent and Guardian Notification

(1) A fundamental goal of the University is to support students' independence and maturity, in part by encouraging them to assume responsibility for their own educational and personal matters. The University also encourages students and parents or guardians to communicate directly, regularly, and openly with each other about issues of mutual concern.

(2) Under laws and policies that govern the privacy rights of students, Southern Oregon University has the authority and reserves the right to contact parents or guardians of dependent students about a variety of serious matters and the parents or guardians of all students in certain emergencies regarding imminent serious injury or life or death situations. Parental or guardian notification may occur under the following circumstances:

(a) Hospital visits for alcohol poisoning or drug overdose;

(b) Behavior or circumstances which put the student at an imminent safety risk, including repeated or alarming levels of prohibited substance abuse;

(c) Serious mental health concerns.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Hist.: SOU 2-2009, f. 8-5-09 cert. ef. 8-7-09; SOU 2-2013, f. & cert. ef. 6-20-13

573-076-0110
Disciplinary Files and Records

(1) The formal hearing process prompts creation of a disciplinary file in the Office of Student Affairs. The file contains information related to the incident as well as the following:

(a) Any written statements from earlier documents bearing the name of the student violator which have been maintained at the residence hall level.

(b) Copies of letters regarding prior disciplinary matters.

(c) Any subsequent correspondence related to the case.

(d) Materials related to sanctions.

(e) Other reports at the discretion of the Director or designee.

(2) Accused students involved in disciplinary processes may review the contents of this confidential file (to the extent that the materials therein do not compromise the confidentiality of other students, faculty or staff), and may contest in writing anything in the file.

(3) Disciplinary records of students will be destroyed pursuant to the Oregon University System retention schedule governing institutional records. Prior access is granted to students who have requested access before the records are destroyed, and the State Archivist is empowered to order the retention of some categories of records.

(4) Student conduct files are maintained permanently in the event of dismissal.

(5) Student conduct records of students who have not yet responded to allegations will remain active. Once they have responded, the records are retained in accordance with the procedures above.

(6) Student conduct records may be voided by the Director or designee for good cause, upon written petition of the student. Factors to be considered in review of such petitions include:

(a) The present demeanor of the student;

(b) The conduct of the student subsequent to the violation;

(c) The length of time between the violation and the request;

(d) The nature of the violation and the severity of any damage, injury, or harm resulting from it.

(7) Disciplinary files are treated as "education records" under the provisions of the Family Education Rights and Privacy Act (FERPA) and may be viewed only by those who "need to know" such information in the conduct of their official duties, as determined by the Director or designee. Otherwise, content of the file may be released to others only with consent of the student whose name is on the file.

(8) A maximum delay of forty-five (45) days is authorized in granting access to education records involving students.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Hist.: SOU 2-2009, f. 8-5-09 cert. ef. 8-7-09; SOU 2-2013, f. & cert. ef. 6-20-13

573-076-0120
Interpretation and Revision

(1) Any question of interpretation regarding this Code and University Policy must be referred to the Director or designee for final determination.

(2) This Code and University policies are reviewed annually under the direction of the Director or designee, who consults with students, faculty, and staff as appropriate.

(3) Changes to the Code recommended through this consultative process are subject to approval by the Executive Council of the University.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Hist.: SOU 2-2009, f. 8-5-09 cert. ef. 8-7-09; SOU 2-2013, f. & cert. ef. 6-20-13

573-076-0130
Prohibited Conduct

(1) Academic Misconduct. University Statement on Academic Misconduct: Each student's education is the product of his or her own intellectual effort and engagement in a process of critical exchange. Breaches of academic integrity compromise the overall quality of scholarship, and detract from the value of the SOU degree. The University must respond to any act of academic misconduct to honor and protect responsible citizenship, both globally and within the University community. Prohibited academic conduct is as follows:

(a) Acts of academic misconduct involve the use or attempted use of any method that enables a student to misrepresent the quality or integrity of his or her academic work and are prohibited.

(b) Academic misconduct with respect to examinations includes but is not limited to copying from the work of another, allowing another student to copy from one's own work, unauthorized use of crib notes during exam time, arranging for another person to substitute in taking an examination, or giving or receiving unauthorized information prior to or during the examination.

(c) Academic misconduct with respect to written or other types of assignments includes but is not limited to:

(A) Failure to acknowledge the ideas or words of another that have been intentionally taken from any published or unpublished source;

(B) Placing one's name on papers, reports, or other documents that are the work of another individual;

(C) Flagrant misuse of the assistance provided by another in the process of completing academic work, or the submission of unacceptably similar work resulting from inappropriate collaboration or assistance.

(D) Submission of the same paper or project for separate courses without prior authorization by faculty members;

(E) Fabrication, alteration, or other manipulation of data; or

(F) Knowingly aiding in or inciting the academic dishonesty of another.

(d) Academic dishonesty with respect to intellectual property includes but is not limited to theft, alteration, or destruction of the academic work of other members of the community, or of the educational resources, materials, or official documents of the University and is prohibited.

(2) Deliberate Acts of Dishonesty. In general, acts of dishonesty are prohibited. Such acts may include, but are not limited to:

(a) Furnishing false and/or misleading information to any University or community official, faculty member, administrative office, or conduct body;

(b) Forgery, alteration, and/or misuse of any University record, document, or instrument of identification;

(c) Bribery and/or coercion;

(d) Fraud and/or other misrepresentation.

(3) Animal Control

(a) The following animal-related behavior is prohibited:

(A) Inhumane or cruel treatment of animals on University premises;

(B) Bringing any animal inside a University Building, with the exception of guide or service animals approved by Disability Resources, or by special permission of the Director for Student Development and Support Services;

(C) Leaving an animal unattended on University premises, even when tethered;

(D) Leaving an animal in a closed vehicle on University premises.

(b) Additionally, resident students may not own or care for pets, other than fish in approved aquaria, in campus residence halls.

(4) Controlled Substances

(a) The unlawful use, abuse, sale, purchase, transfer, possession, manufacture, distribution, or dispensing of alcohol or other drugs on University property or as part of any University activity is prohibited.

(b) Use, possession, cultivation, manufacture, promotion, sale, and/or distribution of narcotics or other controlled substances, except as expressly permitted by law, is prohibited.

(c) Use and/or possession of prescription drugs prescribed to another is prohibited.

(d) The service of alcohol to and/or consumption by any person who is under the age of 21 or is intoxicated is prohibited.

(e) Public intoxication at any age is prohibited.

(f) Intoxication to the point of incapacitation at any age is prohibited.

(g) Common source containers of alcohol, such as kegs, are prohibited on campus except with prior written permission from the Vice President for Student Affairs.

(h) Alcohol and other drugs may not be consumed in the course of any class, laboratory, or other activity at which attendance is required as part of a student's course or degree requirements.

(5) Disorderly Conduct. Loud, aggressive, profane, abusive, drunken, and/or other behavior which disrupts or obstructs the orderly functioning of the University or disturbs the peace and/or comfort of person(s) on campus, on University owned or controlled property, or at University sponsored or supervised functions is prohibited. Exhibiting behavior that creates a concern for harm to self or others, or behavior that suggests a serious problem which is detrimental to the University and University community is prohibited.

(6) Disruption, Obstruction, or Interference. Engaging in, or inciting others to engage in the disruption, obstruction, and/or interference with of any of the following is prohibited:

(a) University student conduct proceedings;

(b) Educational activities in classrooms (both physical and online), lecture halls, campus library, laboratories, computer laboratories, theatres, or any other place where education and teaching activities take place;

(c) Classroom expectations. Disruption, obstruction, or interference includes classroom behavior, which, in the judgment of the instructor, impedes other students' opportunity to learn and/or which interferes with class objectives. This provision includes University classes held on and off Southern Oregon University premises, including distance learning and online courses.

(d) Operations of Campus Public Safety, fire, police, emergency services, and/or residential life staff;

(e) Interference with campus safety instruments;

(f) Any student's ability to study, learn, and/or complete academic requirements including, but not limited to: destroying, preventing, and/or limiting access to information or records;

(g) Intentionally interfering with the freedom of expression of others on University premises or at University sponsored activities;

(h) University activities, including its public service functions, whether on- or off-campus, and other non-University activities which occur on University premises.

(7) Failure to Comply

(a) Failure to comply with University regulations, state and/or federal laws, and/or the directives of University and/or community officials while acting in their duties is prohibited.

(b) Failure to comply with the conditions of the Residential Life Housing Contract is prohibited.

(c) Failure to comply with University student conduct proceedings, including rules governing hearings procedures and sanctions imposed by University student conduct officials is prohibited.

(8) Gambling. Illegal gambling or wagering on University premises, or at any official function sponsored by the University is prohibited.

(9) Harassment, Discrimination, or other Abusive Behavior

(a) Physical or written/verbal abuse, threats, intimidation, harassment, coercion, or other conduct directed at a specific person, which threatens the health and safety of any person or seriously alarms or intimidates another person is prohibited.

(b) Written abuse, intimidation, or harassment through the use of Internet peer-networking sites, weblogs, or other online media which is open to the public is prohibited.

(c) Remarks, actions, or gestures which have the purpose or effect of creating an intimidating, hostile, and/or offensive working, campus living, and/or academic experience due to a race, color, sex, religion, age, marital status, national origin, gender identity or expression, the presence of any physical or sensory disability, veteran status, sexual orientation or any other basis protected by applicable local, state or federal law is prohibited.

(d) University Statement on Hate and Bias-motivated language: The University appreciates the complexity of defining language and actions that are not acceptable in a community which values freedom of expression. All members of the SOU community must be free to hold views that others may find distressing or offensive. However, freedom of expression does not include the right to intentionally and maliciously aggravate, intimidate, ridicule, or humiliate another person.

(10) Hazing. Any act which endangers the mental or physical health or safety of a student, or which destroys or removes public or private property, for the purpose of initiation, admission into, affiliation with, or as a condition for continued membership in a group or organization is prohibited.

(11) Interference with Community Standards. Verbal or physical threats and/or intimidation of a person participating in a student conduct proceeding in any capacity is prohibited. Influencing or attempting to influence another person to commit an abuse of community standards is prohibited. Attempting to influence the impartiality of a member of a conduct body prior to, and/or during the course of, the conduct proceeding is prohibited. Failure to comply with the sanction(s) imposed under the Code is prohibited.

(12) Misuse of Emergency Equipment and Procedures

(a) Tampering with, damage of, or intentional misuse of emergency devices or blocking of fire exits or other means of impeding traffic is prohibited.

(b) Use of fire escapes, ground level fire doors, fire hoses, extinguishers, and/or alarm equipment in non-emergency situations is prohibited.

(c) Failure to comply with fire drill procedures or emergency building evacuation is prohibited.

(d) Initiating a false report or warning, or the threat of fire, explosion, false fire alarm, or other emergency is prohibited.

(13) Weapons & Destructive, Chemical, and/or Incendiary Devices

(a) On-campus use, possession, storage (unless authorized), or manufacture of the following is prohibited:

(A) Firearms or other devices capable of casting a projectile;

(B) Any weapon, device, instrument, material, or substance which is designed to, or may by use, inflict injury upon another person;

(C) Explosives, bombs, or other incendiary or destructive devices;

(D) Fireworks of any kind.

(b) Attempting, committing, or aiding the intentional commission of an act which results in a fire being ignited which causes damage, or is intended to cause damage, to the property of the University, to the property of another individual, or to personal property is prohibited.

(14) Noise. Activities in violation of established quiet hours in residence halls and academic buildings or which violate local, state or federal noise ordinances is prohibited.

(15) Obstruction. Obstruction of the free flow of pedestrian or vehicular traffic on University premises or at University-sponsored or supervised functions is prohibited.

(16) Sexual Misconduct. Sexual Misconduct is defined as any sexual contact or sexual behavior that is non-consensual and/or inflicted upon someone who is incapacitated, and/or forced, and is prohibited. Additionally, Sexual Exploitation, and Sexual Harassment are prohibited. Definitions, as outlined by the Oregon University System, are as follows:

(a) Sexual Contact means the touching of the genitalia, anus, buttocks, breasts or mouth, as well as, any contact for the purpose of sexual gratification.

(b) Sexual Behavior means any action, short of sexual contact, done for purposes of sexual gratification, and may include but is not limited to voyeurism, exposing, masturbation, frottage, and audio/video recording.

(c) Non-consensual is the absence of shared sexual permission. Shared sexual permission is clear, voluntary, non-coerced and clearly indicates a willingness to participate in sexual contact/behavior, whether through affirmative verbal responses or non-verbal communication unmistakable in meaning and given by an adult (age 18 or older). Shared sexual permission to one form of sexual contact/behavior does not operate as permission to any other or the same form of sexual contact/behavior.

(d) Incapacitation is a mental or physical condition that renders a person unable to grant consent. Incapacitation may be a state or condition resulting from the use of alcohol or other drugs, or lack of sleep, sleep, and unconsciousness. Incapacitation may also be the result of a cognitive impairment, such as a developmental disability, brain injury, or mental illness.

(e) Force includes but is not limited to physical force, violence, abuse, threat of force (direct or implied), intimidation, extortion, harassment, coercion, fraud, duress or pressure.

(f) Sexual Exploitation occurs when a person takes non-consensual, unjust or abusive advantage of another in a sexual or intimate context, for his/her own advantage or benefit, or to benefit or advantage of anyone other than the one being exploited, and that behavior does not otherwise constitute non-consensual sexual misconduct. Sexual exploitation includes permitting or facilitating non-consensual viewing, taking of photographs, videotaping, or audio taping of sexual or intimate activity, knowingly inflicting another person with HIV or other sexually transmitted infection, inducing incapacitation of another person with the intent to facilitate sexual misconduct against that person, and/or compelling prostitution.

(g) Sexual Harassment includes unwelcome sexual advances, requests for sexual favors, and other physical conduct of a sexual nature when:

(A) Submission to such conduct is made a term or condition of employment or academic advancement (explicitly or implicitly).

(B) Submission or rejection to such conduct is used as a basis for employment or academic advancement decisions, or

(C) Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or learning environment; or creating an intimidating, hostile or offensive work, academic, residential living, or any University-related environment.

(17) Smoking. Smoking is prohibited:

(a) In any University building;

(b) Within 25 feet of any University building;

(c) In any University vehicle;

(d) In any other designated areas.

(18) Stalking. Stalking is a pattern of repeated harassment by unwanted attention and/or contact, and is prohibited. Stalking includes, but is not limited to:

(a) Following or lying in wait for the victim

(b) Repeated unwanted, intrusive, and frightening contact from the perpetrator by phone, mail, email, etc.

(c) Damaging the victims property

(d) Making direct or indirect threats to harm the victim, the victim's children, relatives, friends, or pets

(e) Repeatedly sending the victim unwanted gifts.

(f) Harassment through the Internet, known as "cyberstalking," "online stalking," or "Internet stalking."

(g) Securing personal information about the victim by accessing public records, using Internet search devices, hiring private investigators, contacting friends, family, work, or neighbors, going through the victim's garbage, following the victim, etc.

(19) Theft. Attempted or actual theft and/or damage to University property or property of students, other members of the University, or others legitimately using College property is prohibited.

(20) Vandalism or Unauthorized Use of Property. Unauthorized use and/or abuse of University property is prohibited. Such acts may include, but are not limited to:

(a) Alteration, duplication, and/or misuse of keys, University documents, or identification;

(b) Unauthorized entry into, or use of, University premises or equipment, including but not limited to camping, building a fire, or use of an unauthorized heating, cooking or electrical device.

(c) Damage, vandalism, misuse, or theft of University property, or the property of another person, group, or agency;

(e) Graffiti, which is defined as intentionally defacing public and/or private property, regardless of the purpose;

(f) Littering, which is defined as throwing, discarding, placing, or depositing items in University buildings or on University grounds, except in receptacles provided for such purposes.

(21) Unwelcome Use of Electronic Devices. Unwanted communication with another person using computers, email, cell phones, or any other digital device is prohibited. Abuse, misuse, and/or theft of computer data, equipment, and/or software, including unauthorized file-sharing and distribution of electronic materials is also prohibited.

(22) Violation of Local, State, or Federal Laws. Violation of local, state, or federal laws on or off University premises that may be reasonably expected to have a negative impact on the University or members of the University community in any form is prohibited.

(23) Violent, Threatening, Coercive, or Abusive Conduct. Examples of prohibited violence and abusive behavior include, but are not limited to, the following:

(a) Slapping, punching, or otherwise physically attacking a person;

(b) A direct or implied threat of harm or hostile behavior that creates a reasonable fear of injury to another person or unreasonably subjects another individual to emotional distress;

(c) Brandishing a weapon or an object which appears to be a weapon in a threatening manner;

(d) Intimidating, threatening, or directing abusive language toward another person;

(e) Intentionally damaging University property and/or the property of a member of the SOU community or a visitor;

(f) Committing acts motivated by and/or related to racial or sexual harassment or domestic violence;

(g) Retaliation and/or harassment against a person making a report in good faith.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Hist.: SOU 2-2009, f. 8-5-09 cert. ef. 8-7-09; SOU 3-2011, f. & cert. ef. 6-13-11; SOU 2-2013, f. & cert. ef. 6-20-13

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Rule Caption: Parking Enforcement and Appeals
Adm. Order No.: SOU 3-2013
Filed with Sec. of State: 6-20-2013
Certified to be Effective: 6-20-13
Notice Publication Date: 5-1-2013
Rules Amended: 573-050-0015, 573-050-0016, 573-050-0025, 573-050-0030, 573-050-0040
Subject: This amendment in Div. 050 edits language to correct subsections of the rule.
Rules Coordinator: Treasa Sprague—(541) 552-6319

573-050-0015
Definitions

(1) For the purpose of these regulations, the word "parking" means any vehicle which is stopped and/or waiting, regardless of the period of time the vehicle is stopped or whether a driver is present, except for a vehicle immobilized by traffic control, congestion, or accident.

(2) The word "vehicle" means any type of motor-powered conveyance including, but not limited to, automobiles, trucks, trailers, motorcycles, mopeds, scooters, bicycles, skateboards, personal assistive mobility devices and all methods of transportation on wheels.

(3) The word "permit" as used in these regulations includes all the following:

(a) Faculty/Staff decal/hang tag.

(b) Student Commuter decal;

(c) Residence Hall decal;

(d) Motorcycle and Scooter decal;

(e) Carpool decal;

(f) Temporary Substitute permit;

(g) Weekly Parking permit;

(h) Guest Parking permit;

(i) Service Vehicle permit;

(j) Daily Parking permit.

(k) Special Permits

(4) A "decal" is the permanent permit affixed to a vehicle.

(5) The word "permit" means a valid decal or permit as recognized by the Parking Department.

(6) Service vehicles are defined as University-owned service trucks or cars, vehicles with commercial permits, or vehicles with special temporary service permits performing a service for Southern Oregon University.

(7) Delivery vehicles are defined as vehicles owned by companies doing pick-up and delivery business with the University departments or vehicles with temporary special delivery permits on pick-up and delivery business.

(8) Dangerous driving includes but is not limited to wrong way driving, high speed, spinning tires or operating a vehicle not under control.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 352.360
Hist.: SOSC 5, f. & ef. 9-2-76; SOSC 4-1979, f. 8-8-79, ef. 9-1-79; SOSC 5-1980, f. & ef. 8-19-80; SOSC 4-1982, f. & ef. 7-28-82; SOSC 6-1983, f. & ef. 8-23-83; SOSC 2-1984, f. & ef. 8-14-84; SOSC 8-1985, f. & ef. 8-12-85; SOSC 5-1987, f. & ef. 9-8-87; SOSC 2-1996, f. & cert. ef. 8-2-96; SOU 2-2011, f. & cert. ef. 6-13-11; SOU 2-2012, f. & cert. ef. 6-11-12; SOU 3-2013, f. & cert. ef. 6-20-13

573-050-0016
Service Vehicles, Delivery Vehicles, and Loading Zones

(1) Loading Zones:

(a) Loading zones are located throughout the campus and are reserved for people loading and unloading heavy or bulky packages;

(b) Signed loading zones are limited to 30-minute occupancy;

(c) Loading zones are enforced at all times unless otherwise posted.

(2) Loading Docks:

(a) Loading docks are reserved for delivery vehicles;

(b) Under special circumstances, a private vehicle may be issued special use permission at Campus Public Safety;

(c) Loading docks are enforced at all times unless otherwise posted.

(3) Service Vehicles Spaces:

(a) Spaces are reserved for service vehicles;

(b) Under special circumstances, a private vehicle may be issued special use permission at Campus Public Safety.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 352.360
Hist.: SOU 2-2011, f. & cert. ef. 6-13-11; SOU 3-2013, f. & cert. ef. 6-20-13

573-050-0025
Vehicle Permits, Parking Areas and Fee Schedule

(1) All vehicles parked on the University campus are required to display a valid SOU permit when the posted signs require a permit. Faculty/Staff lots are posted yellow; Student Commuter lots are posted green; Resident Student lots are posted red. Parking Services can be contacted for the location where other types of permits may be obtained. Failure to display a permit may result in the issuance of a parking citation. Permits may be purchased during normal office hours at the Enrollment Services Center (ESC) located in Britt Hall. All permits are valid for the current academic year only, unless otherwise designated by Parking Services at the time of issuance; there are no open-ended permits.

(a) Permit is defined as any Parking Services sanctioned or issued permit. Examples include: decal, hangtag, guest, special, metered, temporary, courtesy*, media, or other placard or device issued or developed by Parking Services as needed to facilitate parking of vehicles on Southern Oregon University property. *(A courtesy permit refers to a Retiree, VIP, or a Volunteer.) Any misuse of these parking permits may cause them to be revoked.

(2) Parking permits and faculty/staff hangtags are serialized for use on specific vehicle(s) with a license plate designated by the purchaser at the time of purchase. Permits (decals) must be affixed outside to left-rear bumper, left-rear body, left-rear window, or rear-side window behind driver of the vehicle where visible. The adhesive on the back of the permit must be the attaching mechanism. Hangtags are to be hung from the rear-view mirror; serialized numbers facing out. Parking Services (at the Enrollment Services Center in Britt Hall) must be informed of changes in vehicles; re-registering the hangtags to the appropriate vehicle(s). If a vehicle is disposed of, the permit must be removed and returned to Parking Services.

(3) Parking permits may be purchased for the time period designated on the decals; generally the academic year. The academic year begins and ends in September. Parking permits purchased during the winter, spring, or summer terms are at a proportionately reduced rate.

(4) Faculty/Staff (yellow) parking permits (or hangtags) will be sold to classified employees, graduate assistants, temporary employees who are half-time or more, and faculty. Faculty/staff employees working .50 FTE or less will be eligible for a permit at a reduced rate of one-half the cost of the permit. Hangtags are issued for a three-year period. Faculty/staff hangtags are considered the first permit. They are not to be sold as a second permit. Vehicles displaying a Faculty/Staff permit (yellow) (or hangtag) are authorized to park in designated Faculty/Staff (yellow) parking areas or Student parking areas (red parking areas or green parking areas).

(5) Student Commuter parking (green) permits will be sold to students who live off campus and wish to bring vehicles on campus. Vehicles displaying a Student Commuter permit are authorized to park in designated Student Commuter (green) parking areas.

(6) Residence Hall (red) parking permits will be sold to students living in campus residence halls. Vehicles displaying a Residence Hall permit are authorized to park in designated Residence Hall (red) parking areas.

(7) Second parking permits may be purchased for an additional vehicle if more than one vehicle will be brought to campus. The purchaser must also be the registered owner of the vehicle. Only one permit (the original or second permit) is valid in permit-required lots at a time. If both first and second permits of one person are parked in permit-required lots at the same time, both vehicles will be cited for improper permits. A second permit may not be purchased for a car if the first permit is for a vehicle used in a Residence Hall Parking area, a motorcycle, moped, or scooter.

(8) A replacement permit may be obtained for a damaged, unreadable permit or for a replacement vehicle. The replacement vehicle must be registered to the same owner as the original vehicle. The permit which is being replaced will be considered void and should be returned to Parking Services (at the Enrollment Services Center in Britt Hall) upon purchase of a replacement permit.

(9) Guest permits are available at Parking Services and departmental offices. Guest permits are issued for one day only. Guest permits may not be used in timed or visitor pay meter lots. Guest permits will not be valid if issued to University employees, faculty, students, buses, or vehicles displaying a valid parking permit. Guest permits will not be valid and a citation may be issued for failure to display permit if any of the following information is illegible or omitted:

(a) Both license number and make or color of vehicle;

(b) Date that permit is valid;

(c) Name and telephone extension of departmental personnel issuing the permit.

(10) Carpool parking permits will be sold for the entire school year only if the carpool meets the following criteria:

(a) The carpool must contain at least two registered participants but no more than six.

(b) No more than one vehicle from the carpool is allowed on campus at a particular time. They may not purchase a second permit. However, replacement permits are available if requirements as stated in the regulations for replacement permits are met.

(11) Temporary replacement vehicles for a vehicle with a permit may be brought on campus after obtaining a Substitute Vehicle parking permit from Parking Services. This permit is used for temporary situations of short duration (30 days or less).

(12) Special permits may be approved by Parking Services on an as-needed basis.

(13) Weekly or Daily permits, for those persons who use the campus parking facilities only intermittently, may be purchased at Parking Services (at the Enrollment Services Center in Britt Hall) or may be available in departments that have purchased them for use in special programs or events on campus.

(14) Courtesy (purple), parking permits are available to Emeritus Faculty only. Courtesy (purple), permits are valid for Emeritus Faculty only, not to be used by family or friends. A grandfather clause exists for employees who have already received a purple permit prior to the effective date of this rule. Volunteer board members, designated governmental officials, media representatives, and such others as deemed necessary by the President will have dated and numbered VIP hangtags to facilitate their interaction with the institution. Media representatives will receive dated and numbered hangtags. Permits may be used only for their intended purpose.

(15) Vendor or Volunteer permits may be obtained through Parking Services.

(a) Commercial permits will be sold to commercial vendors, including vending machine, video game, outside maintenance, travel, office supply, and food vendor companies, and contractors' employees. Companies or departments can purchase a long-term permit for six months or a year. Short-term permits are available for one day or one month. Companies or departments will be billed for the permits by Parking Services.

(b) Volunteer parking permits will be sold to departments for use by volunteers. Departments can purchase long-term permits for one year, short-term permits for less than one month or term-by-term. These permits will be billed by Parking Services to the issuing department. Volunteer per-

mits are not valid if issued to current University employees, faculty or students.

(16) Disabled parking is in accordance with ORS 811.602, 811.605, 811.606, 811.607, and 811.615. Only vehicles displaying a disabled placard or license plate issued and registered at the Motor Vehicles Division (as designated in Rule 573-050-0020) will be allowed to park in spaces posted for use by disabled persons. These vehicles must also display an SOU permit or meter permit unless otherwise posted.

(a) Temporary placards are issued by the Motor Vehicle Division for persons with qualifying temporary disabilities (as provided by ORS 811.606 and 811.640). The requirements for parking on campus apply for all disabled parking listed above.

(b) Vehicles with an appropriate disabled placard or license plate and SOU permit may park in any lot or space without incurring citations, except where the lot or space is designated for parking limited to 60 minutes or less in a parking space reserved for other vehicles, or visitor-pay meter lots.

(17) Refunds will be given for student/staff parking permits for unused academic terms, except summer term. No refunds will be given for year permits that are not used summer term. Refunds will be given upon return of the permit or fragments thereof showing the permit numbers and expiration date. Refund schedules are on file at ESC.

(18) Vehicles displaying valid permits are not guaranteed a parking space on the campus.

(19) Vehicles displaying valid permits are not exempt from timed parking restrictions. Vehicles may park in a timed space or in a metered parking space but must comply with the time limits or metered fee payment of the specific space.

(20) Mopeds, scooters, & motorcycles must have a motorcycle permit and be parked in a motorcycle parking space. If a motorcycle has a full price vehicle parking permit they may park in a vehicle space that corresponds with the color of the permit. Motorcycles may park in timed spaces that are open to the public. Mopeds, scooters, and motorcycles parked in bicycle racks and on the campus grounds will be cited for improper parking. Vehicles parked inside University buildings will be towed at the owner's expense.

(21) If a faculty/staff hangtag is the first legal permit, and a motorcycle is the second vehicle, a decal may be purchased at second decal rate.

(22) If, during the process of issuing a parking citation, the driver of the violating vehicle drives away from the scene, thus preventing the issuing agent from placing the citation on the vehicle, the citation will be entered into the parking system as if it had been placed on the vehicle. When a driver leaves the scene during the issuing process, this will be considered "constructive notice" of the citation.

(23) Vehicles parked facing in the direction against one-way arrows will be cited for improper parking. Vehicles parked on the side of street opposing direction of usual traffic flow will be cited for improper parking.

(24) Vehicles using parking lots marked "Pay Parking" are required to display the serialized meter permit purchased at each lot of this type. Failure to display the meter permit in plain view on the left side of the vehicle's dashboard will result in a citation for failure to display a permit. There is no grace period to obtain change for the permit machine.

(25) Government Vehicles not assigned a permanent parking space may only be parked for a period of 24 hours in Faculty/Staff or Student parking spaces unless permission has been obtained from Parking Services. Vehicles may be liable for enforcement action for non-compliance.

(26) Buses may park where directed by Parking Services.

(27) Fee Schedule:

(a) Carpool, sold for entire school year only: $135 each pool.

(b) Faculty and staff decal for first-registered vehicle, fall term through summer term: $143.

(c) Faculty/staff hangtags are issued for a three-year period: $430.

(A) This fee is for a one-time purchase.

(B) Payroll deduction is available, plus applicable increases in permit fees.

(d) Student Commuter and Residence Hall decal for first-registered vehicle for only fall term through summer term: $135.

(e) Motorcycles, mopeds, and scooters, one vehicle only:

(A) Fall term through summer term: $55.

(B) If motorcycles park in auto spaces, the fee is commensurate with full auto fee for the area.

(f) Second Vehicle permit: $46.

(A) Second permits will be sold only to Faculty/Staff and Commuter permit holders. Red permit holders may not purchase a second permit.

(B) One second permit is allowed for each full-price (first-registered vehicle) permit purchased.

(C) Replacement permits can be obtained only in accordance with OAR 573-050-0025(8).

(g) Replacement permits or hangtags: $29.

(h) Lost/stolen permits: $23.

(i) Departmental Reserved Parking spaces (nonrefundable): $100 over and above price for regular parking permit and a $50 fee for each subsequent sign-change after a sign is posted.

(j) Commercial permit, each vehicle:

(A) Long-term, twelve months: $187.

(B) Long-term, six months: $111.

(C) Short-term, one month: $30.

(D) Short-term, daily: $11.

(k) Weekly parking permits: $30 per week (available at Housing, and Parking Services).

(l) Daily parking permits: $11 per day (available at Housing, and Parking Services).

(m) Department Daily Guest Pass booklets: $46.

(n) Evening and weekend parking in designated lots: $1.

(o) Visitor pay parking in specified lots: $1 per hour (lot 12, and lot 29; in lot 1, pay $0.25 per hour). Lots 27, 30, 32, are $1.00 per visit after 6 PM and weekends.

(p) Volunteer permit:

(A) Volunteer, each vehicle, long-term, one year: $8.

(B) Volunteer, each vehicle, short-term, less than one month: $3.

(q) Handling charges:

(A) Deducting fines from payroll check: $8.

(B) Out-of-state Department of Motor Vehicles research fee: $8.

Stat. Auth.: ORS 351.070

Stats. Implemented: ORS 352.360

Hist.: SOSC 5, f. & ef. 9-2-76; SOSC 4-1979, f. 8-8-79, ef. 9-1-79; SOSC 5-1980, f. & ef. 8-19-80; SOSC 3-1981, f. & ef. 9-9-81; SOSC 4-1982, f. & ef. 7-28-82; SOSC 1-1983, f. & ef. 1-3-83; SOSC 6-1983, f. & ef. 8-23-83; SOSC 2-1984, f. & ef. 8-14-84; SOSC 8-1985, f. & ef. 8-12-85; SOSC 3-1986, f. & ef. 7-22-86; SOSC 5-1987, f. & ef. 9-8-87; SOSC 4-1989, f. & cert. ef. 9-19-89; SOSC 3-1990, f. & cert. ef. 5-31-90; SOSC 4-1991, f. & cert. ef. 6-11-91; SOSC 2-1994, f. & cert. ef. 6-10-94; SOSC 2-1996, f. & cert. ef. 8-2-96; SOU 2-1997, f. & cert. ef. 8-26-97; SOU 2-1998, f. & cert. ef. 7-16-98; SOU 1-1999, f. & cert. ef. 5-7-99; SOU 2-2000, f. & cert. ef. 6-9-00; SOU 1-2001, f. & cert. ef. 4-4-01; SOU 2-2002, f. & cert. ef. 6-28-02; SOU 1-2004, f. & cert. ef. 4-5-04; SOU 3-2006, f. & cert. ef. 6-29-06; SOU 3-2007, f. & cert. ef. 7-23-07; SOU 3-2009, f. 10-1-09, cert. ef. 10-4-09; SOU 3-2010, f. & cert. ef. 6-8-10; SOU 2-2011, f. & cert. ef. 6-13-11; SOU 2-2012, f. & cert. ef. 6-11-12; SOU 3-2013, f. & cert. ef. 6-20-13

573-050-0030

Driving and Parking Regulations on Campus

The Vice President for Administration and Finance, in consultation with the Transportation Planning and Parking Committee (TPPC), will designate parking areas on campus.

(1) Anyone operating a vehicle on campus will observe posted speed limits, barricades, bicycle lanes, crosswalks, and stop signs and will drive in a safe and prudent manner. The speed limit on campus is 15 MPH. Driving or parking vehicles, bicycles, motorcycles, mopeds, scooters, or motorized bicycles on sidewalks, lawns, and other areas not designated for driving, parking, or public thoroughfare is prohibited.

(2) Regulations may change from time to time. In the event of conflict between traffic signs or markings and printed regulations, the signs or markings will prevail.

(3) Vehicles shall be parked within indicated parking areas only. All lots will have permit requirements suspended during institution holidays except disabled, yellow zones, pay lots, reserved parking spaces, and restricted areas, which are enforced at all times. "Holidays" refers to the following observed state holidays: New Year's Day, Martin Luther King, Jr. Day, Memorial Day, Independence Day, Labor Day, Veterans' Day, Thanksgiving Day and the Friday following Thanksgiving, and Christmas Day.

(4) Residence Hall (red) parking areas, and pay lots are enforced 24 hours a day except for holidays as specified in the previous paragraph. All other lots are enforced as indicted herein:

(a) Faculty/staff (yellow) enforced 6A-6P, after 6P and weekends any university permit is valid.

(b) Commuter lots (green) enforced 6A-6P, after 6P and weekends any university permit is valid. All lots are enforced 24 hours per day unless otherwise posted.

(5) Persons, departments, or schools sponsoring University-hosted or community events must contact the Parking Services event coordinator online or contact Parking Services (at the Enrollment Service Center in Britt Hall) to arrange for parking and fee payment as appropriate. Unless otherwise arranged, participants will be restricted to Lot 1 during the academic school year. Event is defined as any activity occurring on Southern Oregon University property in which the sponsors or attendees pay a fee,

collectively utilize more than 5 permit area spaces, or requires services from Parking Services.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 352.360
Hist.: SOSC 5, f. & ef. 9-2-76; SOSC 4-1979, f. 8-8-79, ef. 9-1-79; SOSC 5-1980, f. & ef. 8-19-80; SOSC 3-1981, f. & ef. 9-9-81; SOSC 6-1983, f. & ef. 8-23-83; SOSC 2-1984, f. & ef. 8-14-84; SOSC 3-1986, f. & ef. 7-22-86; SOSC 5-1987, f. & ef. 9-8-87; SOSC 4-1989, f. & cert. ef. 9-19-89; SOSC 2-1994, f. & cert. ef. 6-10-94; SOU 2-1997, f. & cert. ef. 8-26-97; SOU 2-1998, f. & cert. ef. 7-16-98; SOU 1-1999, f. & cert. ef. 5-7-99; SOU 2-2002, f. & cert. ef. 6-28-02; SOU 1-2004, f. & cert. ef. 4-5-04; SOU 3-2006, f. & cert. ef. 6-29-06; SOU 3-2007, f. & cert. ef. 7-23-07; SOU 3-2013, f. & cert. ef. 6-20-13

573-050-0040
Penalties for Offenses

Multiple violations may be cited for a single incident:

(1) Failure to display valid permit: Fine $30.

(2) Fraudulent display of permit: Fine $85.

(3) Permit not affixed: Fine $25.

(4) Improper permit: Fine $20.

(5) Parking in disabled space: Maximum fine $450.

(6) Overtime parking: Fine $25.

(7) Blocking wheel chair ramp: Fine $100.

(8) Improper parking: Fine $30.

(9) Parking in reserved space: Fine $75.

(10) Blocking traffic: Fine $50.

(11) Boot vehicle: Fine $25.

(12) Abandoning a vehicle: Fine $100.

(13) A vehicle may be towed off campus property and impounded at the owner's expense (including additional fines) under the following circumstances:

(a) Any vehicle is causing imminent danger to people or University property;

(b) Any vehicle is without a valid yellow, green, or red parking permit and has records of $100 or more in unpaid citations (may be towed or booted);

(c) Any vehicle is left parked or standing in an area not normally used for parking, including parking on a sidewalk or on grass;

(d) Any vehicle is improperly parked in a disabled space;

(e) Any vehicle is blocking traffic, another vehicle, any door or fire exit, access to any trash container, fire lane, crosswalk, driveway, or it poses any other safety hazard (may also be cited for blocking traffic);

(f) Any vehicle is determined to be abandoned on University property.

(14) Vehicles in timed parking areas may be cited when their time parked exceeds the posted time limit. The vehicle may be cited again after double the posted time limit is exceeded.

EXAMPLE: In a 30-minute parking area, a vehicle may be cited after 30 minutes; again after a total of 90 minutes (including the first 30 minutes); again after 150 minutes and so forth. Timed parking is defined as "limited duration" meaning one time parking per timed lot during a 24 hour period. Re-parking in the same lot constitutes continuous parking and the vehicle will be cited.

(15) Vehicles parked in permit-required parking areas may be cited every eight hours, not to exceed three citations every 24 hours.

(16) Other violations not defined by 1-15 above. $50

(17) Depositing litter or debris on a University parking lot, roadway or bikeway. $50

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 352.360
Hist.: SOSC 5, f. & ef. 9-2-76; SOSC 4-1979, f. 8-8-79, ef. 9-1-79; SOSC 5-1980, f. & ef. 8-19-80; SOSC 4-1982, f. & ef. 7-28-82; SOSC 6-1983, f. & ef. 8-23-83; SOSC 2-1984, f. & ef. 8-14-84; SOSC 8-1985, f. & ef. 8-12-85; SOSC 3-1986, f. & ef. 7-22-86; SOSC 5-1987, f. & ef. 9-8-87; SOSC 4-1989, f. & cert. ef. 9-19-89; SOSC 3-1990, f. & cert. ef. 5-31-90; SOSC 4-1991, f. & cert. ef. 6-11-91; SOSC 2-1994, f. & cert. ef. 6- 10-94; SOSC 2-1996, f. & cert. ef. 8-2-96; SOU 2-1997, f. & cert. ef. 8-26-97; SOU 2-1998, f. & cert. ef. 7-16-98; SOU 1-1999, f. & cert. ef. 5-7-99; SOU 1-2001, f. & cert. ef. 4-4-01; SOU 2-2002, f. & cert. ef. 6-28-02; SOU 1-2004, f. & cert. ef. 4-5-04; SOU 3-2006, f. & cert. ef. 6-29-06; SOU 3-2007, f. & cert. ef. 7-23-07; SOU 3-2009, f. 10-1-09, cert. ef. 10-4-09; SOU 2-2011, f. & cert. ef. 6-13-11; SOU 3-2013, f. & cert. ef. 6-20-13

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Oregon University System, University of Oregon
Chapter 571

Rule Caption: Amend special fees, fines, penalties, and service charges to include FY 2013-2014 rates.
Adm. Order No.: UO 3-2013
Filed with Sec. of State: 6-27-2013
Certified to be Effective: 6-27-13
Notice Publication Date: 5-1-2013
Rules Amended: 571-060-0005

Subject: The University has determined that the adoption of the amendments to the fee list will be necessary in order to provide the basis for funding to cover the expenses of the services rendered and to maintain a current schedule of fees, fines, and penalties.

Copies of the permanent rule amendments to General & Family Housing Rates, Room and Board Rates, Course Fees, and Non-Course Fees may be obtained from Amanda Hatch, Rules Coordinator, at ahatch@uoregon.edu or 541.346.3082.

Other permanent rule amendments can be found at the following website: http://brp.uoregon.edu/special-fees-fines-book.
Rules Coordinator: Amanda Hatch—(541) 346-3082

571-060-0005
Special Fees, Fines, Penalties, Service Charges

The University of Oregon has adopted by reference a list of Special Fees, Fines, Penalties, Service Charges, etc., for the current fiscal year:

(1) The fees, fines, penalties and service charges listed by reference in this rule are updated annually and copies are on file in the listed departments by July 1.

(2) The amounts and conditions of these fees may change from time to time throughout the year due to administrative considerations, changing costs, changes in institutional budgets, etc. If the size and the amount of these fees are or could be of importance to users, they should verify the details prior to making a commitment, before entering into any planning activities or before actually incurring any charges.

(3) The master copy of the current list of fees is maintained in the Office of the Director of Business Affairs and is available upon request to any person during regular business hours. The Director of Business Affairs also maintains a bulletin board where fee changes made during each 30-day period are posted. Following that posted period, the changes are filed within the master copy.

(4) University departments charging fees shall maintain a copy of at least that department's section of the list of special fees, fines, penalties and service charges including any updates made during the course of the fiscal year. The list and all current changes shall be available upon request to any person during regular departmental business hours.

(5) No department may change fees between annual amendments to this rule without first obtaining an approved statement of justification signed by the appropriate Vice-President. Prior to granting approval of any fee charged to students, the Vice-President shall consult with the Office of Student Advocacy. Changes in fees approved by the Vice-President and the justification statement shall be posted for 15 days in a public area of the departmental office. The new fee, fine, penalty or charge becomes effective at the end of the 15-day posting period after it is filed with the Director of Business Affairs along with the justification statement.

(6) However, student loan service charges, charges levied as penalties for prohibited conduct, general tuition, building fees, incidental fees, health service fees, and residence hall and housing charges, shall be adopted in accordance with the provision of ORS 183.310 to 183.500.

(7) Certain charges, fees or fee schedules may, according to ORS 351.072(b), be adopted without compliance with rulemaking provisions of ORS 183.310 to 183.500. They are: charges relating to symposiums, conferences, short courses, food, books or other retail goods, prices of admission to athletic, entertainment or cultural events or advertising rates in student or institutional publications.

Stat. Auth.: ORS 351.070, 351 & 352
Stats. Implemented: ORS 351.070
Hist.: UOO 20, f. & cert. ef. 4-27-76; UOO 34(Temp), f. & cert. ef. 8-8-77; UOO 37, f. & cert. ef. 9-30-77; UOO 3-1978, f. & cert. ef. 7-1-78; UOO 1-1979(Temp), f. 6-26-79, ef. 7-1-79; UOO 4-1979, f. & cert. ef. 10-3-79; UOO 7-1980, f. 6-30-80, ef. 7-1-80; UOO 7-1981 (Temp), f. 6-16-81, ef. 7-1-81; UOO 9-1981(Temp), f. & cert. ef. 6-29-81; UOO 2-1982, f. & cert. ef. 4-14-82; UOO 4-1982, f. & cert. ef. 6-10-82; UOO 4-1983, f. & cert. ef. 6-10-83; UOO 5-1983(Temp), f. & cert. ef. 6-15-83; UOO 2-1984, f. 6-11-84, ef. 7-1-84; UOO 3-1985, f. 6-19-85, ef. 7-1-85 UOO 1-1986; f. 6-4-86, ef. 7-1-86; UOO 4-1986(Temp), f. & cert. ef. 11-10-86; UOO 7-1986(Temp), f. 12-30-86, ef. 1-1-87; UOO 8-1986(Temp), f. 12-30-86, ef. 1-1-87; UOO 1-1987, f. & cert. ef. 1-29-87; UOO 3-1987, f. 6-17-87, ef. 7-1-87; UOO 6-1988, f. 6-29-88, cert. ef. 7-1-88; UOO 8-1988, f. & cert. ef. 8-17-88; UOO 5-1989, f.6-20-89, cert. ef. 7-1-89; UOO 7-1990, f. 6-14-90, cert. ef. 7-1-90; UOO 9-1991, f. 6-12-91, cert. ef. 7-1-91; UOO 1-1992, f. 4-9-92, cert. ef. 7-1-92; UOO 2-1993, f. 4-19-93, cert. ef 7-1-93; UOO 9-1993, f. & cert. ef. 6-15-93; UOO 11-1993, f. 8-29-93, cert. ef. 9-1-93; UOO 2-1994, f. 6-13-94, cert. ef. 7-1-94; UOO 3-1994, f. 6-14-94, cert. ef. 7-1-94; UOO 4-1995, f. 6-13-95, cert. ef. 7-1-95; UOO 5-1995, f. 7-31-95, cert. ef. 8-1-95; UOO 3-1996, f. 6-6-96, cert. ef. 7-1-96; UOO 6-1997, f. 6-18-97, cert. ef. 7-1-97; UOO 7-1997, f. 6-18-97, cert. ef. 7-1-97; UO 1-1998, f. 6-17-98, cert. ef. 7-1-98; UO 2-1998, f. 6-17-98, cert. ef. 7-1-98; UO 2-1999, f. 6-1-99, cert. ef. 7-1-99; UO 3-1999, f. 6-1-99, cert. ef. 7-1-99; UO 2-2000, f. 6-15-00, cert. ef. 7-1-00; UO 1-2001, f. 6-18-01, cert. ef. 7-1-01; UO 2-2001, f. 6-18-01, cert. ef. 7-1-01; UO 2-2002, f. 6-19-02, cert. ef. 7-1-02; UO 3-2002, f. 6-19-02, cert. ef. 7-1-02; UO 1-2003, f. 6-23-03, cert. ef. 7-1-03; UO 2-2003, f. 6-23-03, cert. ef. 7-1-03; UO 2-2004, f. 5-11-04, cert. ef. 7-1-04; UO 3-2004, f. 6-30-04, cert. ef. 7-1-04; UO 6-2007, f. & cert. ef. 2-22-07; UO 8-2007, f. & cert. ef. 3-12-07; UO 9-2007, f. 5-10-07, cert. ef. 6-29-07;

UO 11-2007, f. 6-19-07, cert. ef. 6-29-07; UO 2-2008, f. 5-6-08, cert. ef. 7-1-08; UO 4-2008, f. 6-27-08, cert. ef. 7-1-08; UO 1-2009, f. 4-24-09, cert. ef. 7-1-09; UO 2-2009 f. 6-30-09, cert. ef. 7-1-09; UO 1-2010, f. 4-22-10, cert. ef. 7-1-10; UO 2-2010, f. 7-29-10, cert. ef. 7-30-10; UO 2-2011, f. 6-22-11, cert. ef. 7-1-11; UO 1-2012, f. 6-4-12, cert. ef. 7-1-12; UO 3-2012(Temp), f. 6-13-12, cert. ef. 7-1-12 thru 12-21-12; UO 5-2012, f. & cert. ef. 8-13-12; UO 2-2013, f. & cert. ef. 3-6-13; UO 3-2013. f. & cert. ef. 6-27-13

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Oregon Watershed Enhancement Board
Chapter 695

Rule Caption: Revisions to water acquisition grant rules to implement an efficient, transparent, streamlined grant-making process.
Adm. Order No.: OWEB 2-2013
Filed with Sec. of State: 6-19-2013
Certified to be Effective: 6-19-13
Notice Publication Date: 5-1-2013
Rules Adopted: 695-046-0175, 695-046-0180, 695-046-0185, 695-046-0190, 695-046-0195, 695-046-0200, 695-046-0205, 695-046-0210, 695-046-0215, 695-046-0220, 695-046-0225, 695-046-0230
Rules Amended: 695-046-0010, 695-046-0020
Rules Repealed: 695-046-0025, 695-046-0030, 695-046-0040, 695-046-0050, 695-046-0060, 695-046-0070, 695-046-0080, 695-046-0090, 695-046-0100, 695-046-0110, 695-046-0120, 695-046-0130, 695-046-0140, 695-046-0150, 695-046-0160, 695-046-0170
Subject: OWEB is amending and repealing some current rules and adopting new rules related to the administration of the water acquisition grant program. The purpose of this rulemaking is to develop an efficient, streamlined process for grant-making. Specifically, minor revisions will be made to purpose [695-046-0010] and definition of water acquisition project [695-046-0020]. Rules outlining the previous water acquisition grant process [i.e., 695-046-0025 through 695-046-0170] will be repealed. These rules will be replaced by newly adopted rules describing the following components and requirements of the streamlined grant-making

process: Nature of Application [695-046-0175]; Application and Subsequent Grant Processing Requirements [695-046-0180]; Use of Grant Funds [695-046-0185]; Matching Contributions [695-046-0190]; Coordinating and Partnering with Other Funders [695

-046-0195]; Application Evaluation Process [695-046-0200]; Public Involvement [695-046-0205]; Board Approval and Delegation of Authority [695-046-0210]; Director's Funding Approval and Distribution of Funds [695-046-0215]; Compliance and Enforcement [695-046-0220]; Subsequent Conveyances [695-046-0225]; and Waiver and Periodic Review of Rules [695-046-0230].
Rules Coordinator: Renee Davis-Born—(503) 986-0029

695-046-0010
Purpose

The purpose of this rule is to supplement the OWEB Grant Program rules under OAR 695-005 and to add specific guidance regarding the OWEB water acquisition grant program. The Oregon Watershed Enhancement Board does not itself hold an interest in water rights in grants authorized under these rules, but rather allocates funding for water allocation projects to other entities to hold the interest in water rights, subject to their contractual and statutory obligations and the compliance requirements set forth in OAR 695-046-0220.

Stat. Auth.: ORS 541.906
Stats. Implemented: ORS 541.932(9)
Hist.: OWEB 2-2005, f. & cert. ef. 2-1-05; OWEB 2-2013, f. & cert. ef. 6-19-13

695-046-0020
Definition of Water Acquisition Project

(1) "Water Acquisition Project is a program or project that plans for or implements, or both, the acquisition of an interest or interests in water from a willing seller for the purpose of increasing instream flow to do either or both of the following:

(a) Address the conservation needs of habitats and species;

(b) Improve water quality in a water-quality-limited area as determined by the Oregon Department of Environmental Quality.

(2) A water acquisition project may include the following activities:

(a) Strategic planning and development, project design, landowner outreach, and other activities associated with water acquisitions in a given basin or other defined area;

(b) Acquisition of an interest in water and associated due diligence;

(c) Monitoring and other associated activities to ensure the interest is maintained through time.

Stat. Auth.: ORS 541.906
Stats. Implemented: ORS 541.932(9)
Hist.: OWEB 2-2005, f. & cert. ef. 2-1-05; OWEB 2-2013, f. & cert. ef. 6-19-13

695-046-0175
Nature of Application

In accordance with Section 4(b) of Article XV of the Oregon Constitution, OWEB may consider grant applications in partnership with other funders for projects that plan or implement the acquisition of an interest in water from willing sellers for the purpose of maintaining or restoring watersheds and habitat(s) for native fish or wildlife. Interest in water includes, but is not limited to, instream leases (including split season use instream leases), water use agreements that result in protectable instream flows, conserved water projects as determined by the Oregon Water Resources Department's Allocation of Conserved Water Program, and permanent and time-limited instream transfers. These projects must be designed to increase instream flow to do either or both of the following:

(1) Address the conservation needs of habitats and species; or

(2) Improve water quality in a water-quality-limited area as determined by the Oregon Department of Environmental Quality. Applications must address the conservation and restoration needs of habitat(s) and species consistent with ecological priorities and principles identified by the Board.

Stat. Auth.: ORS 541.906
Stats. Implemented: ORS 541.932(9)
Hist.: OWEB 2-2013, f. & cert. ef. 6-19-13

695-046-0180
Application and Subsequent Grant Processing Requirements

(1) Grant applications for water acquisition projects must be submitted on the most current form that conforms with the process prescribed by the Board.

(2) This Board-prescribed process may be conducted in cooperation with other funders of water acquisition projects.

(3) In the event of any conflict between these requirements and requirements identified in OAR 695-005, the water acquisition requirements in this division will take precedence.

Stat. Auth.: ORS 541.906
Stats. Implemented: ORS 541.932(9)
Hist.: OWEB 2-2013, f. & cert. ef. 6-19-13

695-046-0185
Use of Grant Funds

Water acquisition grant funds may be applied towards reasonable costs, as determined by OWEB, related to the planning and/or implementation of acquisition of interest in water from willing sellers, including:

(1) The purchase price and the purchase option fees associated with acquisition of an interest in water.

(2) The monetary interest on loans.

(3) The staff costs incurred as part of acquiring the interest in water.

(4) The cost of water-owner outreach activities necessary for the funded project.

(5) The cost of due diligence activities, including appraisal or valuation of the interest to be acquired, title report, assessment of the timing and extent of water use and regulation associated with the interest in water, Oregon Water Resources Department application costs, and other customary due diligence activities.

(6) The legal fees incurred.

(7) The transfer and closing fees related to the acquisition of an interest in water.

(8) The cost of monitoring the acquisition to certify that the water interest is being used and managed consistent with Section 4(b), Article XV of the Oregon Constitution.

Stat. Auth.: ORS 541.906
Stats. Implemented: ORS 541.932(9)
Hist.: OWEB 2-2013, f. & cert. ef. 6-19-13

695-046-0190
Matching Contributions

(1) All applicants shall demonstrate at least 25% of the actual water acquisition project cost is being sought as match, with the grant applicant required to provide matching funds and efforts necessary to complete the purchase. The following costs and activities will qualify as match:

(a) All costs listed under OAR 695-046-0185, including in-kind contributions of those costs.

(b) Funding commitments made by others as a result of grant applicant efforts (including funding to be secured from other funders as part of a Board-prescribed process conducted in cooperation with other funders).

(c) Any donated portion of the interest in water.

(2) OWEB funds provided under OAR 695-046-0185 shall not qualify as matching contributions.

(3) The Director retains the discretion to determine that specific matching costs are unreasonable in a particular grant context and would not be recognized as qualifying matching costs.

Stat. Auth.: ORS 541.906
Stats. Implemented: ORS 541.932(9)
Hist.: OWEB 2-2013, f. & cert. ef. 6-19-13

695-046-0195
Coordinating and Partnering with Other Funders

OWEB may consider grant applications in partnership with other funders for the purpose of creating operational efficiencies and better coordinating investments in water acquisitions to maintain or restore watersheds and habitat(s) for native fish or wildlife that are designed to increase instream flow to do one or both of the following:

(1) Address the conservation needs of habitats and species; or

(2) Improve water quality in a water-quality-limited area as determined by the Oregon Department of Environmental Quality.

Stat. Auth.: ORS 541.906
Stats. Implemented: ORS 541.932(9)
Hist.: OWEB 2-2013, f. & cert. ef. 6-19-13

695-046-0200
Application Evaluation Process

(1) Grant applications for water acquisition projects shall be evaluated in accordance with guidance (including priorities, principles, and process) adopted and periodically reviewed by the Board and made available to the public via the agency's website and Board meeting materials.

(2) The evaluation may be conducted in cooperation with other funders.

(3) The grant application evaluation process shall include reviews for:

(a) The consistency of the water acquisition project with the Board's established priorities and principles for water acquisitions.

(b) The significance of the projected ecological outcomes.

(c) The business plan for the water acquisition project, including:

(A) Socio-economic strategy, including the community impacts or benefits resulting from the project (including, but not limited to, description of both current and proposed water uses, potential effects on existing water rights and uses, and other relevant socio-economic information).

(B) The capacity of the grant applicant to complete the acquisition and to achieve and sustain the proposed ecological outcomes over time.

(C) The soundness of the planning and of the legal and financial terms of the proposed water acquisition project, and its feasibility to achieve the projected ecological outcomes.

(D) Priority will be given to projects that are planned or implemented, or both, by grant applicants with a sound program to acquire interests in water rights to address the conservation needs of habitats and species and improve water quality in a water-quality-limited area, as determined by the Oregon Department of Environmental Quality.

Stat. Auth.: ORS 541.906
Stats. Implemented: ORS 541.932(9)
Hist.: OWEB 2-2013, f. & cert. ef. 6-19-13

695-046-0205
Public Involvement

The public shall be provided with opportunities to comment on grant applications for water acquisition projects being considered by the Board. OWEB will provide written notice through its website of the Board's intent to consider water acquisition grant applications. The Board will accept:

(1) Written comments received at least 14 days before the Board meeting at which the application is to be considered by the Board; and

(2) Oral comments made at the Board meeting at which the grant application is considered.

Stat. Auth.: ORS 541.906
Stats. Implemented: ORS 541.932(9)
Hist.: OWEB 2-2013, f. & cert. ef. 6-19-13

695-046-0210
Board Approval and Delegation of Authority

The Board shall conditionally approve grants in accordance with guidance adopted by the Board and made available to the public. The Director is delegated the responsibility of ensuring that funding conditions required by the Board are fully satisfied by the grant applicant.

Stat. Auth.: ORS 541.906
Stats. Implemented: ORS 541.932(9)
Hist.: OWEB 2-2013, f. & cert. ef. 6-19-13

695-046-0215
Director's Funding Approval and Distribution of Funds

The Director may approve the distribution of grant funds when:

(1) The terms of the proposed acquisition of an interest in water are approved by the Director.

(2) A grant agreement is executed by the Director and either the grant applicant or the entity or entities identified under the Board-prescribed process for other funders as referenced under OAR 695-046-0180. In the latter case, the other funder(s) must subsequently execute a grant agreement with the applicant to utilize OWEB funds in support of a water acquisition project. The Director has reconciled conditionally-approved funding with actual costs.

(3) The grant applicant has satisfied the match requirements under 695-046-0190.

Stat. Auth.: ORS 541.906
Stats. Implemented: ORS 541.932(9)
Hist.: OWEB 2-2013, f. & cert. ef. 6-19-13

695-046-0220
Compliance and Enforcement

(1) The ongoing use of the water interest acquired with OWEB water acquisition grant funds shall be consistent with the purposes specified in section 4(b) Article XV of the Oregon Constitution. If significant compliance issues cannot be resolved to the full satisfaction of the Director, the Director, after informing the Board and providing reasonable written notice to the recipient of the grant, may in his or her discretion initiate any and all legal remedies available to OWEB, including recovery of the OWEB grant funds that were used to purchase the water interest, and reasonable interest and penalties at the option of the Director.

(2) OWEB, its grantees, contractors and cooperating agencies must be provided sufficient legal access to property to which the water interest acquired with OWEB funds is appurtenant, for the purpose of monitoring to certify that the water interest is being used and managed consistent with Section 4(b), Article XV of the Oregon Constitution.

Stat. Auth.: ORS 541.906
Stats. Implemented: ORS 541.932(9)
Hist.: OWEB 2-2013, f. & cert. ef. 6-19-13

695-046-0225
Subsequent Conveyances

A water interest acquired with OWEB grant funds shall not be conveyed to another party unless the conveyance is approved by the Board, and may not be conveyed for the purpose of consumptive uses.

Stat. Auth.: ORS 541.906
Stats. Implemented: ORS 541.932(9)
Hist.: OWEB 2-2013, f. & cert. ef. 6-19-13

695-046-0230
Waiver and Periodic Review of Rules

The Director may waive the requirements of Division 46 for individual grant applications, not including mandatory statutory requirements, when doing so is reasonably calculated to result in more efficient or effective implementation of the Board's water acquisition grant program. Any waiver must be in writing and included in the grant file to which the waiver applies. The administrative rules for water acquisition grants shall be periodically reviewed by the Board and revised as necessary and appropriate.

Stat. Auth.: ORS 541.906
Stats. Implemented: ORS 541.932(9)
Hist.: OWEB 2-2013, f. & cert. ef. 6-19-13

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Psychiatric Security Review Board
Chapter 859

Rule Caption: PSRB Conditional Release of Clients with a Department of Corrections Detainer
Adm. Order No.: PSRB 2-2013
Filed with Sec. of State: 6-20-2013
Certified to be Effective: 6-20-13
Notice Publication Date: 4-1-2013
Rules Amended: 859-070-0010, 859-070-0015
Rules Repealed: 859-070-0010(T), 859-070-0015(T)
Subject: (1) Amends existing rules regarding conditional release of clients. ORS 161.346(1)(b) directs the PSRB to conditionally release clients who can be adequately treated and controlled in the com-

munity. Some PSRB clients who are committed to the state hospital who are appropriate for conditional release to a community mental health agency also have a Department of Corrections (DOC) detainer. The DOC detainer prevents the Board from conditionally releasing those clients into the community under the supervision of a county mental health program until their DOC sentence is served. Consequently, the Board's practice has been to conditionally release these clients to DOC after conducting a hearing and determining they can be adequately treated and controlled at DOC. Additionally, there are instances when a PSRB client commits a new crime which results in a conviction with a DOC sentence. Some courts immediately transport these individuals directly from court to Department of Corrections although technically still committed to the state hospital. This rule would establish the written policy to conditionally release these clients to DOC.

(2) Repealing duplicative temporary rules 859-070-0010 and 859-070-0015.

Rules Coordinator: Juliet Follansbee—(503) 229-5596

859-070-0010
Board Order of Conditional Release

In determining whether an order of conditional release is appropriate, the Board shall have as its goals the protection of the public, the best interests of justice, and the welfare of the individual. The Board may consider the testimony and exhibits at the hearing regarding the patient's behavior in the hospital including the patient's progress, insight and responsibility taken for the patient's own behavior:

(1) If the Board finds the person may be controlled in the community and a verified conditional release plan is approved by the Board, the Board may order the person placed on conditional release. If a person has a DOC detainer, the Board may order conditional release to that agency if the Board finds that the patient no longer needs a hospital level of care and that the patient could be adequately controlled and treated and the supervision and treatment necessary are available in that DOC setting.

(2) If the Board finds the person could be controlled in the community or DOC but no conditional release plan has been approved by the Board, the Board may order the person committed but find the person appropriate for conditional release pending submission of a conditional release plan signed by either a mental health community provider or DOC. The Board may specify what conditions the plan should include and may approve the conditional release plan submitted by the staff of the hospital, by the patient or someone on the patient's behalf at an administrative hearing.

(3) If a verified conditional release plan has not been approved and the conditions need further examination and approval of the Board, the Board may commit the patient, find the patient appropriate for conditional release or continue the hearing.

Stat. Auth.: ORS 161.387
Stats. Implemented: ORS 161.336 & 161.646
Hist.: PSRB 1-1985, f. 1-3-85, ef. 1-15-85; PSRB 1-1995, f. & cert. ef. 1-11-95; PSRB 1-2013(Temp), f. 2-22-13, cert. ef. 3-1-13 thru 8-26-13; PSRB 2-2013, f. & cert. ef. 6-20-13

859-070-0015
Elements of Conditional Release Order

The Board shall consider any or all of the following elements of a conditional release plan and determine which are appropriate and necessary to insure the safety of the public:

(1) Housing: Housing must be available for the patient. The Board may require 24-hour supervised housing, a supervised group home, foster care, housing with relatives or independent housing.

(2) Mental health treatment: Mental health treatment must be available in the community or at DOC. The Board-approved provider of the treatment must have had an opportunity to evaluate the patient and the proposed conditional release plan and to be heard before the Board. The Board shall not require an evaluation be performed by DOC staff prior to consideration of conditional release due to the nature of that state agency, its security and its resources for the provision of mental health services. The provider must have agreed to provide the necessary mental health treatment to the patient. The treatment may include: individual counseling, group counseling, home visits, prescription of medication or any other treatment recommended by the provider(s) and approved by the Board.

(3) Reporting responsibility: An individual must be available to be designated by the Board as having primary reporting responsibility and must have agreed to:

(a) Notify the Board in writing of the patient's progress at least once a month unless the patient is housed at DOC in which case progress reports will be submitted upon request of the Board;

(b) Notify the Board promptly of any grounds for revocation under OAR 859-080-0010;

(c) Notify the Board promptly of any significant changes in the implementation of the conditional release plan;

(d) Coordinate and monitor all elements of the conditional release plan.

(4) Special conditions: Special conditions may be imposed, including, but not limited to, the following: no consumption of alcohol, taking of antabuse, observation by designated individual of each ingestion of medication, submitting to drug screen tests, no driving, vocational activities, day treatment, attending school, working, or sex offender assessment and treatment.

(5) Parole and probation: Parole and probation supervision may be ordered.

(6) Agreement to conditional release: Patients shall agree to and sign a form promising to comply with the general conditions of release. This signed form shall be made a part of the conditional release plan. The conditions shall include notice that if the person leaves the state without authorization of the Board, the person may be charged with a new crime of escape. This subsection does not apply to a patient who is conditionally released to DOC.

Stat. Auth.: ORS 161.387
Stats. Implemented: ORS 161.336 & 161.646
Hist.: PSRB 1-1985, f. 1-3-85, ef. 1-15-85; PSRB 1-1995, f. & cert. ef. 1-11-95; PSRB 1-2013(Temp), f. 2-22-13, cert. ef. 3-1-13 thru 8-26-13; PSRB 2-2013, f. & cert. ef. 6-20-13

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Public Utility Commission
Chapter 860

Rule Caption: Temporary Rule Amendments to Define Low-Income Eligibility Requirements for the Oregon Telephone Assistance Program (OTAP).
Adm. Order No.: PUC 5-2013(Temp)
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Rules Suspended: 860-033-0055(T)
Subject: The temporary amendments change Oregon Telephone Assistance Program (OTAP) eligibility requirements to conform to federal criteria set by the Federal Communications Commission (FCC). The temporary rule changes are necessary to: (1) implement the FCC's amended rules resulting from its Lifeline Reform Order 12-11, in which the FCC acknowledged that eligibility criteria for Lifeline varied among the states and identified a need for uniformity; (2) implement new and revised reporting requirements for eligible telecommunications carriers (ETCs) so that this Commission can maintain its opt-out approval status from the FCC's National Lifeline Accountability Database established in the FCC Lifeline Reform Order 12-11; (3) minimize the effect on the RSPF of exponential growth of the number of recipients by removing the compensatory obligations to ETCs for enrolling new customers and for costs incurred as a consequence of participating in OTAP; (4) ensure the quality of information ETCs disseminate to the public about the OTAP; and (5) make housekeeping, organizational, and other clarifying improvements.
Rules Coordinator: Diane Davis—(503) 378-4372

860-033-0001
Applicability

(1) The rules in this Division apply to all telecommunications providers including, but not limited to cellular, wireless, or other radio common carriers that offer service in Oregon with access to the Oregon Telecommunications Relay Service and to the applicants for and recipients of RSPF benefits.

(2) Upon request or its own motion, the Commission may waive any of the division 33 rules for good cause shown. A request for waiver must be made in writing, unless otherwise allowed by the Commission.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040 & 1987 OL Ch. 290
Hist.: PUC 3-1999, f. & cert. ef. 8-10-99; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 6-2011, f. & cert. ef. 9-14-11; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13

860-033-0005
Definitions

For the purpose of this division:

(1) "Basic Service" means "basic telephone service" as defined in OAR 860-032-0190. For qualifying low-income recipients, basic service also includes access to toll-limitation services.

(2) "Competitive Provider" means a competitive telecommunications provider as defined in ORS 759.005(2)(a) that provides services authorized under ORS 759.020.

(3) "Cooperative" means a cooperative corporation or association that provides local exchange telecommunications service within its own exchanges, is organized under ORS Chapter 62, and is certified under ORS 759.025(2).

(4) "Duplicate Support" means an OTAP recipient is receiving two or more Lifeline supported services concurrently or two or more recipients in a household are receiving Lifeline or Tribal Link Up support concurrently.

(5) "Economic unit" means all individuals contributing to and sharing in the income and expenses of a household, including individuals with no income who benefit from another individual's financial support.

(6) "Eligible Telecommunications Carrier" means a provider of telecommunications service, including a cellular, wireless, or other common carrier, that is certified by order of the Commission as eligible to receive federal universal service support throughout a designated service area by having met the eligibility criteria set forth in 47 C.F.R. § 54.201 (2008) and in Commission Order 06-292.

(7) "Eligible Telecommunications Provider" means a provider of telecommunications service, including a cellular, wireless, or other common carrier, that is certified by order of the Commission as eligible to provide OTAP to its qualifying customers throughout a designated service area by having met the following eligibility criteria:

(a) Offers services under 47 C.F.R. §54.101 (2008) using either its own facilities or a combination of its own facilities and resale of another carrier's services (including the services offered by another Eligible Telecommunications Carrier throughout the service area). Under 47 C.F.R. §54.201(f) (2008), the requirement of using its "own facilities" includes, but is not limited to, purchasing unbundled network elements from another carrier;

(b) Advertises the availability of and the charges for such services using media of general distribution; and

(c) Demonstrates that it will comply with OAR 860-033-0005 through 860-033-0100.

(8) "Household" means any individual or group of individuals who are living together at the same address as one economic unit.

(9) "Income" means all income actually received by all members of a household. This includes but is not limited to salary before deductions for taxes, public assistance benefits, social security payments, pensions, unemployment compensation, veteran's benefits, inheritances, alimony, child support payments, worker's compensation benefits, gifts, and lottery winnings. The only exceptions are student financial aid, military housing and cost-of-living allowances.

(10) "Lifeline Household Worksheet" means a form that the Commission sends to an applicant when the Commission is unable to determine that an applicant and a current OTAP recipient are part of a separate economic unit or household.

(11) "Local Exchange Service" means a "local exchange telecommunications service" as defined in ORS 759.005(3).

(12) "Low-income customer" means an individual who demonstrates eligibility for the Oregon Telephone Assistance Program in OAR 860-033-0030.

(13) "Marketing materials" means all media, including but not limited to print, audio, video, Internet (including email, web, and social networking media), and outdoor signage, that describe the Lifeline-supported service offering.

(14) "Oregon Telephone Assistance Program" or "OTAP" means a program established by the Commission that offers reduced local exchange rates to eligible low-income residential customers. OTAP is the state counterpart to the federal Lifeline program as defined in 47 C.F.R. §54.403.

(15) "Oregon Telecommunications Relay Service" or "OTRS" means a facility authorized by the Commission to provide telecommunications relay service.

(16) "Outstanding Accounts" means amounts owing to the Commission including current accounts receivable and accounts that the Commission has written off through appropriate legal procedures. The term does not include amounts owing to the Commission that have been lawfully discharged through bankruptcy proceedings or amounts that are the subject of a proceeding pending before the Commission.

(17) "Remittance Report" means the reporting form identified by that title that is available on the Commission's website at http://www.oregon.gov/puc/Pages/telecom/rspf/index.aspx.

(18) "Residential Service Protection Fund" or "RSPF" means a legislatively approved fund in the Oregon State Treasury that supports the Oregon Telephone Assistance Program, the Telecommunication Devices Access Program and the Oregon Telecommunications Relay Service.

(19) "RSPF Surcharge" means a specified amount up to 35 cents per month collected from each paying retail subscriber who has telecommunications service with access to the telecommunications relay service, except as provided in OAR 850-033-0006(2).

(20) "RSPF Surcharge Exception Form" means the reporting form identified by that title that is available on the Commissions website at http://www.oregon.gov/puc/Pages/telecom/rspf/index.aspx.

(21) "Telecommunication Devices Access Program" or "TDAP" means a program established by the Commission that provides Assistive Telecommunication Devices or Adaptive Equipment at no additional cost beyond telephone service for customers who are deaf, hard of hearing, speech-impaired, deaf-blind or have a disability.

(22) "Telecommunications provider" includes competitive providers, cooperatives and telecommunications utilities.

(23) "Telecommunications service" means the offering of telecommunications as defined in 47 C.F.R. 54.5 (10-1-08 Edition) for a fee directly to the public, or to such classes of users as to be effectively available directly to the public, regardless of the facilities used.

(24) "Telecommunications utility" means a person who is not a competitive provider and is designated as a telecommunications utility under OAR 860-032-0010.

(25) "Toll Limitation Service" means a service provided by an Eligible Telecommunications Provider that allows an OTAP recipient to choose to block the completion of outgoing toll calls (toll blocking) or to specify a certain toll usage that may be incurred per month or per billing cycle (toll control).

(26) "Tribal Link Up" means an assistance program for eligible residents of Tribal lands seeking telecommunications service from an Eligible Telecommunications Carrier that is receiving high-cost support on Tribal lands.

(27) "Universal Service Administrative Company" means an independent, not-for-profit corporation designated by the Federal Communications Commission as the administrator of the universal service fund.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290
Hist.: PUC 9-1988, f. & cert. ef. 4-28-88 (Order No. 88-415); PUC 5-1992, f. & cert. ef. 2-14-92 (Order No. 92-238); PUC 7-1995(Temp), f. & cert. ef. 8-17-95 (Order No. 95-860); PUC 14-1995, f. & cert. ef. 12-20-95 (Order No. 95-1328); PUC 18-1997, f. & cert. ef. 12-17-97; PUC 18-2000, f. & cert. ef. 10-24-00; PUC 4-2001, f. & cert. ef. 1-24-01; PUC 19-2003, f. & cert. ef. 11-14-03; PUC 16-2004, f. & cert. ef. 12-1-04; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 9-2011, f. & cert. ef. 10-4-11; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13

860-033-0006
Monthly RSPF Surcharge: General Provisions, Remittance Reports and Payment

(1) The surcharge rate and the balance in the RSPF are reviewed annually by the Commission each October. The Commission may adjust the amount of the surcharge to ensure the fund has adequate resources but does not exceed six months of projected expenses. A rate adjustment ordered by the Commission following the annual review becomes effective January 1 of the year following the review.

(2) The surcharge imposed by 1987 Oregon Laws Chapter 290, Section (7)(1) does not apply to entities upon which the state is prohibited from imposing the surcharge by the Constitution or laws of the United States or the Constitution or laws of the State of Oregon including, but not limited to:

(a) Counties and political subdivisions.

(b) Federal, state and municipal government bodies or public corporations. For purposes of this rule, "public corporation" means a corporation formed by a state or local government authority for the public's benefit or

for a public purpose. A regional housing authority qualifies as a public corporation.

(c) Federally chartered corporations specifically exempt from state excise taxes by federal law.

(d) Federally recognized Native-American Tribes, and tribal members who live within federally recognized Indian country and are enrolled members of the tribe with sovereignty over that Indian country.

(e) Foreign government offices and representatives that are exempt from state taxation by treaty provisions.

(f) Interconnection between telecommunications utilities, telecommunications cooperatives, competitive telecommunications services providers certified under ORS 759.020, radio common carriers and interexchange carriers.

(g) Any other agency, organization or person claiming an exemption is required to identify the authority for its claim to a provider. If a telecommunications provider is unable to determine the status of a subscriber the Commission will determine whether the subscriber is exempt.

(3) Collection of RSPF Surcharge.

(a) Each telecommunications provider must collect the RSPF surcharge by charging the specified amount to each retail subscriber with access to the telecommunications relay service, including OTAP eligible subscribers. The RSPF surcharge is applied on a telecommunications circuit designated for a particular subscriber.

(A) One subscriber line is counted for each circuit that is capable of generating usage on the line side of the switched network regardless of the quantity of customer premises equipment connected to each circuit.

(B) For providers of central office based services, the surcharge is applied to each line that has unrestricted connection to the telecommunications relay service. For central office based service lines that have restricted access to the OTRS, the surcharge is charged based on software design.

(b) Each cellular, wireless, or other radio common carrier must collect the RSPF surcharge by charging the specified amount to each retail subscriber with access to the telecommunications relay service, including OTAP eligible subscribers. The surcharge is applied on a per-instrument basis.

(c) Each telecommunications provider and each cellular, wireless, or other radio common carrier must identify the surcharge on each retail customer's bill as a separate line item named "RSPF Surcharge."

(4) A telecommunications provider or a cellular, wireless, or other radio common carrier may remit surcharges due to the Commission by electronic transfer, mail or in person.

(5) The Remittance Report and surcharges are due to the Commission on or before the 21st calendar day after the close of each month and must be received in the Commission's offices no later than 5 p.m. Pacific Standard Time on the due date. A surcharge remittance or Remittance Report postmarked on the due date does not meet the requirements of this section and will not be considered as timely submitted.

(6) Each telecommunications provider and each cellular, wireless, or other radio common carrier must submit the Remittance Report and surcharge with no exceptions. If no surcharge is collected, the telecommunications provider or the cellular, wireless, or other radio common carrier must still submit its monthly Remittance Report specified in section (5) of this rule.

(7) For each billing period that a telecommunications provider or a cellular, wireless, or other radio common carrier fails to submit the surcharge fees in full on or before the due date required by these rules, the telecommunications provider or the cellular, wireless, or other radio common carrier must pay a late payment fee in accordance with OAR 860-001-0050.

(8) If the telecommunications provider or the cellular, wireless, or other radio common carrier fails to remit the surcharge in full on or before the due date, the telecommunications provider or the cellular, wireless, or other radio common carrier must pay interest in accordance with OAR 860-001-0050.

(9) If a telecommunications provider or a cellular, wireless, or other radio common carrier fails to file a Remittance Report as required by these rules, the telecommunications provider or the cellular, wireless, or other radio common carrier must pay a late report fee in accordance with OAR 860-001-0050.

(10) If the amount shown due on a Remittance Report is not paid by the due date, the Commission may issue a proposed assessment to set the sum due. The Commission may waive the late report fee, the late payment fees and the interest on the unpaid surcharge fees, or any combination thereof, if the telecommunications provider or the cellular, wireless, or other radio common carrier files a written waiver request and provides evidence showing that the telecommunications provider or the cellular, wireless, or other radio common carrier submitted the Remittance Report and surcharge fees late due to circumstances beyond its control.

(11) The telecommunications provider or the cellular, wireless, or other radio common carrier must pay a fee in accordance with OAR 860 001-0050 for each payment returned for non-sufficient funds.

(12) The telecommunications provider or the cellular, wireless, or other radio common carrier is responsible for and must pay all costs incurred by the Commission to collect a past-due RSPF surcharge from the telecommunications provider or the cellular, wireless, or other radio common carrier.

(13) Remittance Report Records: A telecommunications provider and a cellular, wireless, or other radio common carrier must keep all records supporting each Remittance Report for three years, or if a Commission review or audit is pending, until the review or audit is complete, whichever is later.

(14) In addition to any other penalty, obligation, or remedy provided by law, the Commission may suspend or cancel the telecommunications provider's certificate of authority to provide telecommunications service in Oregon for its failure to file its Remittance Report or its failure to remit the surcharge in full.

(15) Except as otherwise provided by law, if after an audit or review the Commission determines that the telecommunications provider or the cellular, wireless, or other radio common carrier has remitted an excessive amount, the Commission will provide the telecommunications provider or the cellular, wireless, or other radio common carrier a credit in that amount against sums subsequently due from that telecommunications provider or that cellular, wireless, or other radio common carrier.

(16) A telecommunications provider or a cellular, wireless, or other radio common carrier must submit any revisions to a Remittance Report no later than three years from the due date of the Remittance Report. If the Commission concludes that a telecommunications provider or cellular, wireless, or other common carrier remitted an excessive amount and that refunding the excess would have a material and adverse financial impact on the RSPF, the Commission may enter into an agreement with the telecommunications provider or the cellular, wireless, or other radio common carrier to spread payments of the refunds over a period not to exceed three years.

(17) The RSPF Surcharge Exception Form is due annually by March 15. A telecommunications provider or a cellular, wireless, or other radio common carrier that qualifies for the exception must submit the completed form (in person, electronically, or by mail) so that it is received in the Commission's offices no later than 5 p.m. Pacific Standard Time on March 15.

(18) In computing any period of time prescribed or allowed by these rules, the first day of the act or event is not included. The last day of the period is included, unless the last day is a Saturday or legal holiday; then the period runs until the end of the next day that is not a Saturday or a legal holiday. Legal holidays are those identified in ORS 187.010 and 187.020.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290
Hist.: PUC 19-2003, f. & cert. ef. 11-14-03; PUC 16-2004, f. & cert. ef. 12-1-04; PUC 18-2004, f. & cert. ef. 12-30-04; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 1-2010, f. & cert. ef. 5-18-10; PUC 9-2011, f. & cert. ef. 10-4-11; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13

860-033-0007
Estimated Report

(1) For any period for which a telecommunications provider, or a cellular, wireless, or other radio common carrier fails to file a Remittance Report and remit the surcharge payments as required by these rules, the Commission may determine a proposed assessment based upon any information available to the Commission.

(2) The proposed assessment must not cover a period longer than three years prior to the date of the proposed assessment and must include:

(a) An estimated surcharge amount owed;

(b) A late payment fee equal to 9 percent of the estimated surcharge amount owed, up to a maximum of $500 for that reporting period;

(c) Interest on the estimated surcharge amount owed at the rate of 9 percent per annum from the day the surcharge amount was originally due; and

(d) A late report fee per 860-001-0050(3)(e).

(3) Notwithstanding subsection (2)(c) of this rule, if the telecommunications provider did not hold a certificate of authority, if one was required by law, the Commission has an unlimited time to propose an assessment for the period represented by the non-filed Remittance Report. The proposed assessment must include all late payment fees as specified in this rule.

(4) During the 30-day period allowed for filing a petition for a hearing, the telecommunications provider, or the cellular, wireless, or other radio common carrier may file its Remittance Report and pay the surcharge, late report fee, late payment fee, and interest. The Commission will accept the Remittance Report, surcharge payment, late report fee, late payment fee and interest if correctly calculated in accordance with the original due date for the subject period's Remittance Report and payment.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290
Hist.: PUC 19-2003, f. & cert. ef. 11-14-03; PUC 16-2004, f. & cert. ef. 12-1-04; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 1-2010, f. & cert. ef. 5-18-10; PUC 9-2011, f. & cert. ef. 10-4-11; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13

860-033-0010
OTAP Applicability

The Oregon Telephone Assistance Program (OTAP) is designed to provide a reduced rate or discount for an Eligible Telecommunications Provider's basic service, whether sold separately or in combination with other services, to low-income customers who meet eligibility requirements. An Eligible Telecommunications Provider must offer OTAP reduced rates or discounts with all service offerings that include basic telephone service. Reduced rates or discounts apply to the single line, or service that is functionally equivalent to a single line, serving the eligible recipient's principal residence in Oregon. Eligible Telecommunications Providers and the Commission must treat OTAP data as confidential information, to the extent allowed by law, and OTAP data may be used only for OTAP program purposes.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290
Hist.: PUC 9-1988, f. & cert. ef. 4-28-88 (Order No. 88-415); PUC 5-1992, f. & cert. ef. 2-14-92 (Order No. 92-238); PUC 18-1997, f. & cert. ef. 12-17-97; PUC 19-2003, f. & cert. ef. 11-14-03; PUC 16-2004, f. & cert. ef. 12-1-04; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13

860-033-0030
OTAP Eligibility

(1) A low-income customer demonstrates eligibility for OTAP by application to the Commission on a Commission-approved form demonstrating compliance with this rule.

(2) A low-income customer, one or more of the customer's dependents or the customer's household must:

(a) Receive benefits from one of the following public assistance programs: Medicaid under Title XIX and XXI of the Social Security Act; Supplemental Nutrition Assistance Program; Supplemental Security Income; Federal Public Housing Assistance (Section 8); Low-Income Home Energy Assistance Program; National School Lunch Program's free lunch program; or Temporary Assistance for Needy Families; or

(b) Receive benefits from another Commission-approved low-income public assistance program for which eligibility requirements do not exceed 135 percent of the applicable Federal Poverty Guidelines.

(c) Have income that is at or below 135 percent of the applicable Federal Poverty Guidelines for a household of that size.

(3) The Commission may require a low-income customer to submit documentation demonstrating that he or she qualifies under the program or income based eligibility requirements.

(a) Acceptable documentation of program eligibility includes the current or prior year's statement of benefits from a public assistance program, a notice or letter of participation in a public assistance program, program participation documents, or another official document demonstrating that the low-income customer, one or more of the low-income customer's dependents or the low-income customer's household receives benefits from a qualifying assistance program.

(b) Acceptable documentation of income eligibility includes the prior year's state, federal, or Tribal tax return; current income statement from an employer or paycheck stub; a Social Security statement of benefits; a Veterans Administration statement of benefits; a retirement or pension statement of benefits; an Unemployment or Workers' Compensation statement of benefit; federal or Tribal notice letter of participation in General Assistance; or a divorce decree, child support award, or other official document containing income information. If the low-income customer presents documentation of income that does not cover a full year, such as current pay stubs, the low-income customer must present the same type of documentation covering three consecutive months within the previous twelve months.

(4) An applicant may be required to furnish his or her social security number before OTAP eligibility can be determined or verified. Failure to do so may result in denial of benefits.

(5) An applicant must sign a written authorization (OTAP application) permitting the Commission to release necessary information to an Eligible Telecommunications Provider and, as necessary, to the following: Federal Communications Commission, Universal Service Administrative Company, Department of Human Services, and the applicant's personal representative or legal guardian.

(6) If a Commission-approved applicant provides a temporary residential address to the Commission, he or she will be required to verify his or her temporary residential address every 90 days. If the customer fails to respond within 30 days of the Commission's attempts to verify the temporary address, the Commission must notify the Eligible Telecommunications Provider to de-enroll the customer from the Lifeline program.

(7) An applicant or customer may not use a post office box as their residential address. The Commission may accept a P.O. Box or General Delivery address as a billing address, but not a residential address.

(8) The OTAP benefit is limited to one single line, or single line equivalent, per economic unit at the applicant's or recipient's principal residence in Oregon.

(a) If the Commission is unable to determine that an applicant and a current OTAP recipient are part of a separate economic unit or household, the applicant must complete and submit to the Commission the Lifeline Household Worksheet.

(b) The Commission may verify annually that the customer continues to be part of a separate economic unit or household.

(c) If the customer fails to respond within 30 days of the Commission's attempts to verify that the customer continues to be part of a separate economic unit or household, the Commission must notify the Eligible Telecommunications Provider to de-enroll the customer from the Lifeline program.

(9) The name of the applicant must appear on the billing statement or account for the telecommunications service in order for that customer to receive OTAP benefits.

(10) At its discretion, the Commission may require an Eligible Telecommunications Provider to provide up to a maximum of three months of OTAP benefits credited to the applicant's account. The qualifying applicant may be required to submit documentation demonstrating that he or she qualifies under the program or income based eligibility requirements in section (2) or (3) of this rule.

(11) The Commission must verify a customer's continuing eligibility. Continuing OTAP eligibility is based on monthly, quarterly or annual verification by the Commission.

(a) The Commission must allow a customer thirty days following the date of the impending termination or de-enrollment letter required to demonstrate continued eligibility. A customer may be required to submit proof of continued eligibility to the Commission.

(b) When the Commission notifies the Eligible Telecommunications Provider of a customer who is not eligible or no longer eligible, the Eligible Telecommunications Provider must de-enroll the customer from the Lifeline program.

(c) After the Commission determines that the customer is not eligible or no longer eligible, the customer may file a written request for a hearing to appeal the determination as specified in the notice of determination.

(d) At the hearing, the customer must provide to the Commission documentation demonstrating that he or she qualifies under the program or income based eligibility requirements listed in section (2) and (3) of this rule.

(12) If the Commission identifies that a customer or household is receiving duplicate support from one or more Eligible Telecommunications Providers, the Commission, at its discretion and based on the available information, will select the Eligible Telecommunications Provider for which the customer must be de-enrolled.

(13) If an OTAP customer does not use the Lifeline service that the Eligible Telecommunications Provider offers at no charge, the Eligible Telecommunications Provider must provide the customer 30 days' notice, using plain language that the customer's failure to use the Lifeline service within the 30-day notice period will result in de-enrollment from the Lifeline program. If the customer uses the Lifeline service within the 30-day notice period, the Eligible Telecommunications Provider may not terminate the customer's Lifeline service.

(14) A customer must submit an OTAP application to the Commission if the customer switches to a different Eligible Telecommunications Provider.

(15) A customer is not required to submit an OTAP application to the Commission if, in a span of 30 days, the customer disconnects and reconnects service with the same Eligible Telecommunications Provider.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290

Hist.: PUC 9-1988, f. & cert. ef. 4-28-88 (Order No. 88-415); PUC 5-1992, f. & ef. 2-14-92 (Order No. 92-238); PUC 11-1995, f. & ef. 11-27-95 (Order No. 95-1217); PUC 6-1997, f. & ef. 1-10-97 (Order No. 97-005); PUC 6-1997, f. & cert. ef. 1-10-97; PUC 18-1997, f. & cert. ef. 12-17-97; PUC 12-1999, f. & cert. ef. 11-18-99; PUC 19-2003, f. & cert. ef. 11-14-03; PUC 16-2004, f. & cert. ef. 12-1-04; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 9-2011, f. & cert. ef. 10-4-11; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13

860-033-0035
OTAP Benefits

(1) A residential customer qualifying for the OTAP benefit pays a reduced monthly rate, as established by the Commission, for basic service, whether sold separately or in combination with other services, provided by an Eligible Telecommunications Provider. The monthly OTAP benefit includes:

(a) The federal Lifeline program support; and

(b) The State of Oregon support of $3.50.

(2) Initial benefits become effective on the date the Commission receives the signed OTAP application (written authorization) from an eligible customer.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290
Hist.: PUC 9-1988, f. & cert. ef. 4-28-88 (Order No. 88-415); PUC 5-1992, f. & cert. ef. 2-14-92 (Order No. 92-238); PUC 18-1997, f. & cert. ef. 12-17-97; PUC 2-2002, f. & cert. ef. 2-5-02; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13

860-033-0040
OTAP Alternatives

(1) In lieu of OTAP participation, a public utility, cooperative corporation or unincorporated association providing local exchange telecommunication service may apply to the Commission for authority to provide low-income telephone assistance through an alternative plan. A public utility, cooperative corporation or unincorporated association's application must demonstrate that:

(a) Customers eligible for OTAP will receive a benefit not less than the benefit the same customers would have received from OTAP;

(b) Customers who qualify for assistance under will also qualify for assistance under the public utility, cooperative corporation or unincorporated association's alternative plan; and

(c) Administrative costs for an alternative plan will be less than or equal to the administrative costs if the public utility, cooperative corporation or unincorporated association participated in OTAP.

(2) A public utility, cooperative corporation or unincorporated association providing low-income telephone assistance under an alternative plan must inform the Commission monthly of the number of subscribers receiving a benefit and the total dollar amount in benefits provided by the public utility, cooperative corporation or unincorporated association's plan.

(3) Eligible subscribers must continue receiving benefits under the Commission plan until the public utility, cooperative corporation or unincorporated association's alternative plan is approved by the Commission and implemented by the public utility, cooperative corporation or unincorporated association.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290
Hist.: PUC 9-1988, f. & cert. ef. 4-28-88 (Order No. 88-415); PUC 18-1997, f. & cert. ef. 12-17-97; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13

860-033-0045
OTAP Compensable Expenses

(1) The Eligible Telecommunications Provider may be compensated for each customer enrolled for the OTAP benefit at the Commission's request. Benefit costs include the revenue the Eligible Telecommunications Provider foregoes by providing local service to qualified low-income customers at the OTAP reduced rate or discount.

(2) To receive compensation, an Eligible Telecommunications Provider must submit a monthly reimbursement form no later than 21 calendar days after the end of the billing period. The Eligible Telecommunications Provider's reimbursement form must indicate the number of qualified customers who were enrolled during the billing period, the number of customers who received the OTAP benefit during the billing period, and the amount of revenue foregone during that same period.

(3) If the Commission overcompensates an Eligible Telecommunications Provider, the Eligible Telecommunications Provider must immediately return the excess RSPF funds once it notifies the Commission or is notified by the Commission of the overcompensation.

(a) If the Commission overcompensates the Eligible Telecommunications Provider as a result of Commission error and the Eligible Telecommunications Provider upon notification of the overcompensation immediately returns the excess RSPF funds, the Eligible Telecommunications Provider is not required to pay interest on the excess RSPF funds.

(b) If the Commission overcompensates the Eligible Telecommunications Provider as a result of Commission error and upon notification the Eligible Telecommunications Provider does not immediately return the excess RSPF funds, the Eligible Telecommunications Provider must pay interest on the excess RSPF funds at the rate set forth in OAR 860-001-0050.

(c) If the Commission overcompensates the Eligible Telecommunications Provider as a result of actions by the Eligible Telecommunications Provider, including, but not limited to, the filing of an incorrect reimbursement form, then upon notification the Eligible Telecommunications Provider must immediately return the excess RSPF funds and pay interest on the excess RSPF funds at the rate set forth in OAR 860-001-0050.

(4) Notice of Proposed Assessment:

(a) If the Eligible Telecommunications Provider is overcompensated and does not timely return the excess RSPF funds as described in section (3) of this rule, the Commission may issue a written proposed assessment for the amount due.

(b) Within 30 days of the service date of the notice of proposed assessment, the Eligible Telecommunications Provider may pay the proposed assessment in full or may file a written petition for a hearing. The written petition for a hearing must clearly specify all the reasons the Eligible Telecommunications Provider disputes the assessment.

(A) If the Eligible Telecommunications Provider pays the proposed assessment in full within 30 days of the service date of the notice of proposed assessment, the Commission will accept the payment and discontinue any further collection activities for that assessment.

(B) If the Eligible Telecommunications Provider timely files a written petition for a hearing under section (b) of this rule, the Commission will grant the Eligible Telecommunications Provider a hearing and provide at least 10 days notice of the time and place of the hearing. The Commission will conduct the hearing under its rules governing hearings and proceedings.

(5) Commission Order: The Commission will enter an order if the Eligible Telecommunications Provider does not respond to the notice of proposed assessment within 30 days of the service date of the notice of proposed assessment or after considering the testimony presented at hearing. Any charges assessed by the Commission in its order become due and payable on the tenth day after the service date of the Commission's order.

(6) If the Eligible Telecommunications Provider does not respond to the Commission order, then the account may be referred to the Department of Revenue or to a collection agency for collection. The Eligible Telecommunications Provider is responsible for and must pay all costs incurred by the Commission to collect a past-due assessed amount from the Eligible Telecommunications Provider.

(7) An Eligible Telecommunications Provider must submit any revisions to a previously filed reimbursement form no later than three years from its due date. If the Commission concludes that refund is due to an Eligible Telecommunications Provider and that the refund would have a material adverse financial impact on the RSPF, the Commission may enter into an agreement with the Eligible Telecommunications Provider to spread payment of the refund over a period of time not to exceed three years.

(8) The Commission may determine the compensation amount based on the costs an Eligible Telecommunications Provider would reasonably incur to accomplish each task referred to in section (1) of this rule. The Commission disburses funds from the RSPF to the Eligible Telecommunications Provider within 45 calendar days after the Commission receives a properly completed reimbursement form.

(9) Each public utility, cooperative corporation or unincorporated association providing low-income telephone assistance under an approved alternative plan may be compensated for benefit and enrollment costs. However, compensation from the RSPF may not be greater than the compensation the public utility, cooperative corporation or unincorporated association would have received had it participated in OTAP.

(10) Governmental agencies contracting with the Commission to certify the eligibility requirements of individuals or to perform other administrative functions authorized by these rules are compensated based on the terms of the contract.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290
Hist.: PUC 9-1988, f. & cert. ef. 4-28-88 (Order No. 88-415); PUC 18-1997, f. & cert. ef. 12-17-97; PUC 19-2003, f. & cert. ef. 11-14-03; PUC 16-2004, f. & cert. ef. 12-1-04; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 9-2011, f. & cert. ef. 10-4-11; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13

860-033-0046
OTAP Accounting, Reporting and Auditing

(1) Based upon accounting procedures approved by the Commission, Eligible Telecommunications Providers must maintain accounting records so that costs associated with OTAP can be separately identified. Records must be provided to the Commission upon request.

(2) Active OTAP Customer Report: The Active OTAP Customer Report is a listing of all customers receiving the OTAP benefit. The listing may include the customers' telephone numbers, addresses or Commission-assigned OTAP Identification Number. Each Eligible Telecommunications Provider must submit monthly to the Commission in an electronic format accessible by the Commission, an Active OTAP Customer Report. The Active OTAP Customer Report must be received by the Commission on or before the close of business of the 21st calendar day of the following month.

(3) Order Activity Report: The Order Activity Report is a listing of all OTAP customers whose service was disconnected or who were de-enrolled for failure to use the Lifeline service for which the Eligible Telecommunications Provider offers at no charge. The Commission may also require additional information such as a listing of all OTAP customers whose telephone numbers or addresses have changed. Each Eligible Telecommunications Provider must submit monthly to the Commission in an electronic format accessible by the Commission an Order Activity Report. The Order Activity Report must be received by the Commission on or before the close of business of the 21st calendar day of the following month.

(4) No Match Report: When the Commission notifies the Eligible Telecommunications Provider of customers who meet eligibility criteria, the Eligible Telecommunications Provider must notify the Commission of any discrepancy that prevents a customer from receiving the OTAP benefit. Notification of discrepancies must be submitted electronically in a format accessible by the Commission.

(5) The Commission reserves the right to audit the records of an Eligible Telecommunications Provider that provides OTAP benefits.

(6) OTAP Records: Each Eligible Telecommunications Provider must keep all OTAP records and supporting documentation for three years, or if a Commission review or audit is pending, until the review or audit is complete, whichever is later.

(a) An Eligible Telecommunications Provider must produce for inspection or audit upon request of the Commission or its authorized representative all OTAP records and supporting documentation. The Commission, or its representative, must allow the Eligible Telecommunications Provider a reasonable time to produce the records for inspection or audit.

(b) In addition to any other penalty allowed by law, the Commission may suspend or cancel an Eligible Telecommunications Provider's certificate of authority to provide telecommunications service for its failure to produce for inspection or audit the records required by this rule.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290
Hist.: PUC 9-1988, f. & cert. ef. 4-28-88 (Order No. 88-415); PUC 5-1992, f. & cert. ef. 2-14-92 (Order No. 92-238); PUC 18-1997, f. & cert. ef. 12-17-97; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13

860-033-0050
Tribal Link-Up

(1) The Commission must determine whether a prospective Tribal Link Up recipient who has executed a certification pursuant to 47 C.F.R. §54.410(d) has previously received a Tribal Link Up benefit at the residential address provided by the prospective subscriber to prevent duplicative support.

(2) Each Eligible Telecommunications Provider must submit weekly to the Commission in an electronic format accessible by the Commission each new and existing Tribal Link Up recipient's full name, residential address, date of birth, social security number or Tribal identification number, if the subscriber is a member of a Tribal nation and does not have a social security number, the telephone number associated with the Link Up support and the date of service activation.

(3) Each Eligible Telecommunications Provider must obtain, from each new and existing subscriber, consent to transmit the information as specified in section (2) of this rule. Prior to obtaining consent, the Eligible Telecommunications Provider must describe to the subscriber, using plain language, the specific information being submitted, that the information is being submitted to the Commission to ensure proper administration of the Tribal Link Up program, and that failure to provide consent will result in the subscriber being denied the Link Up benefit.

(4) If the Commission notifies the Eligible Telecommunications Provider that a prospective subscriber has received a Link Up benefit at the residential address provided by the subscriber, the Eligible Telecommunications Provider may not seek universal service support reimbursement for Tribal Link Up.

(5) When two or more Eligible Telecommunications Providers submit the information required in section (2) of this rule for the same subscriber, only the Eligible Telecommunications Provider whose information was received and processed by the Commission first, as determined by the Commission, will be entitled to reimbursement from the universal service fund for that subscriber.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290
Hist.: PUC 9-1988, f. & cert. ef. 4-28-88 (Order No. 88-415); PUC 8-1989, f. & cert. ef. 6-8-89 (Order No. 89-724); PUC 5-1992, f. & ef. 2-14-92 (Order No. 92-238); PUC 2-1996, f. & ef. 4-18-96 (Order 96-102); PUC 6-1997, f. & cert. ef. 1-10-97; PUC 18-1997, f. & cert. ef. 12-17-97; PUC 2-2002, f. & cert. ef. 2-5-02; PUC 19-2003, f. & cert. ef. 11-14-03; PUC 16-2004, f. & cert. ef. 12-1-04; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13

860-033-0055
Link-Up America Benefits

(1) Security deposit requirements may be waived for a residential applicant who is eligible for Link-Up America and who satisfies the credit requirements of OAR chapter 860, division 021, or if the qualifying low-income applicant voluntarily elects toll blocking, where available, from the provider.

(2) If an applicant does not meet the credit requirements of OAR chapter 860, division 021, or has an outstanding bill with the Eligible Telecommunications Provider, the deposit is not waived and the applicant is subject to the conditions and payment arrangements contained in OAR chapter 860, division 021.

(3) An Eligible Telecommunications Provider must offer a 50 percent reduction in its tariffed line connection charge, up to a maximum reduction of $30, to eligible Link-Up America applicants. This assistance does not cover special features, services, or deposits. Each eligible resident living on federally recognized tribal lands, with initial connection or line extension costs of $130 or more as prescribed in 47 C.F.R. § 54.411 (2008), may receive an additional reduction of up to $70 to cover 100% of the charges between $60 and $130 for a total maximum support amount of $100. A qualifying Tribal Lifeline customer must directly contact the local Eligible Telecommunications Provider to receive tribal Link-Up support.

(4) An Eligible Telecommunications Provider must offer to the Link-Up America recipient a deferred payment schedule for connection charges up to $200. Payment for the connection charges may be deferred for a period not to exceed one year. The Eligible Telecommunications Provider may not charge the Link-Up America recipient interest on the deferred amount during the deferral period. Connection charges include any charges that the provider customarily assesses to connect subscribers to the network. These charges do not include any permissible security deposit requirements.

(5) A Link-Up America recipient who fails to make payments as agreed with the Eligible Telecommunications Provider is subject to disconnection of service pursuant to OAR chapter 860, division 021.

(6) An Eligible Telecommunications Provider's Link-Up America program must allow a customer to receive the benefit of the Link-Up America program for a second or subsequent time only for a principal place of residence with an address different from the address where the Link-Up America assistance was previously provided.

(7) An Eligible Telecommunications Provider may seek reimbursement from the Universal Service Administrative Company, an authorized agent of the FCC.

(8) Upon FCC approval of a Commission OTAP and Link-Up America plan, an Eligible Telecommunications Provider subject to Oregon Law 1987, Chapter 290, must file appropriate tariffs or price lists with the Commission.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 183, 756, 759 & Ch. 290 OL 1987
Stats. Implemented: ORS 756.040, 759.036 & Ch. 290 OL 1987
Hist.: PUC 12-2009, f. & cert. ef. 11-13-09; Suspended by PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13

860-033-0100
Toll Limitation Service and Prohibited Charges

(1) Upon request and availability, a qualifying OTAP recipient is entitled to Toll Limitation Service from an Eligible Telecommunications Provider at no additional charge.

(2) An Eligible Telecommunications Provider must not charge the OTAP recipient:

(a) The federal universal service fund fee on the local service portion of the phone bill;

(b) The local number portability fee; or

(c) The access recovery fee.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290
Hist.: PUC 18-1997, f. & cert. ef. 12-17-97; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13

860-033-0110
Advertising, Marketing and Outreach

(1) An Eligible Telecommunications Provider may not conceal or misstate a material fact about the Lifeline program or OTAP in advertising, marketing materials or other outreach to Oregon consumers.

(2) An Eligible Telecommunications Provider must explain in plain language and disclose in OTAP marketing materials:

(a) That the Eligible Telecommunications Provider's offering is a Lifeline-supported service;

(b) That Lifeline is a government assistance program. This disclosure must be made in a prominent position and in large font;

(c) The name of the Eligible Telecommunications Provider offering the Lifeline-supported service;

(d) That only eligible low-income customers may enroll in Lifeline;

(e) That proof of eligibility may be necessary for enrollment;

(f) That Lifeline is limited to one benefit per household, consisting of either wireline or wireless service; and

(g) That Lifeline is a non-transferable service.

(3) The Eligible Telecommunications Provider must provide the Commission an opportunity to review OTAP marketing materials prior to release.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290
Hist.: PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13

860-033-0530
TDAP Eligibility

(1) A person may apply to receive an Assistive Telecommunication Device or Adaptive Equipment from the Commission. The application must be submitted using the form provided by the Commission. The TDAP application form is available online at http://www.puc.state.or.us/PUC/rspf/tdapapp.pdf, from the Commission and from certain community resources.

(2) A TDAP applicant must provide the Commission with:

(a) Evidence of regular access to a specific telephone number in Oregon;

(b) Evidence of current residency in Oregon; and

(c) A properly completed application including a statement that the applicant is deaf, deaf-blind, hard of hearing, speech or vision impaired, or has a disability that requires adaptive equipment or an assistive telecommunication device to communicate effectively on the telephone. This statement must be signed by:

(A) A licensed physician who may certify that the applicant is deaf, deaf-blind, hard of hearing, speech or vision impaired or has a disability;

(B) An audiologist or a hearing aid specialist who may certify only that the applicant is deaf or hard of hearing;

(C) A speech pathologist who may certify only that the applicant is speech impaired;

(D) A vocational rehabilitation counselor from the Oregon Office of Vocational Rehabilitation Services who may certify that the applicant is deaf, deaf-blind, hard of hearing, speech or vision impaired or has a disability;

(E) A nurse practitioner who may certify that the applicant is deaf, deaf-blind, hard of hearing, speech or vision impaired, or has a disability;

(F) A rehabilitation instructor from the Oregon Commission for the Blind who may certify only that the applicant has a vision impairment.

(d) For a person under 18 years of age, or an adult who is determined to require a legal guardian, a parent or a guardian must apply on that person's behalf and assume full responsibility for the Assistive Telecommunication Device or Adaptive Equipment and services. An emancipated minor is considered an adult. If the application is signed by a person asserting power of attorney for the applicant or by a legal guardian, the person signing the application may be required to provide the Commission with evidence of the power of attorney or legal guardianship.

(3) The Commission may only approve applications for persons certified as deaf, deaf-blind, hard of hearing, speech or vision impaired or who have a disability and cannot use a telephone for expressive or receptive communication.

(4) The Commission may provide one Assistive Telecommunication Device or one Adaptive Equipment unit per eligible person. The one device or unit provided may also include an accessory device such as a loud ringer or signal device, as applicable. More than one Assistive Telecommunication Device or Adaptive Equipment unit may be provided to a household if more than one eligible person permanently resides in the household.

(5) If the Commission purchases new devices that may benefit a TDAP recipient more than the equipment currently provided by the Commission to the recipient, the Commission may allow the recipient to use both the current and new device for a 60-day trial period. The recipient must return the less beneficial equipment to the TDAP within five business days after the end of the trial period. If the recipient fails to return the equipment, the recipient is responsible for paying the Commission for the cost of the more expensive equipment.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290
Hist.: PUC 7-1988, f. & cert. ef. 4-6-88 (Order No. 88-339); PUC 18-1989, f. & cert. ef. 12-14-89 (Order No. 89-1602); PUC 5-1992, f. & cert. ef. 2-14-92 (Order No. 92-238); PUC 18-1997, f. & cert. ef. 12-17-97; PUC 12-1999, f. & cert. ef. 11-18-99; PUC 19-2003, f. & cert. ef. 11-14-03; PUC 16-2004, f. & cert. ef. 12-1-04; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 9-2011, f. & cert. ef. 10-4-11; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13

860-033-0535
Ownership of and Conditions for Use of Assistive Telecommunication Devices or Adaptive Equipment

(1) All Assistive Telecommunication Devices or Adaptive Equipment purchased under the Commission remain the property of the State of Oregon. The Authorized Distributors must record the serial number of each Assistive Telecommunication Device or Adaptive Equipment unit. An Authorized Distributor's failure to comply may terminate the distributor's contract with the State of Oregon.

(2) Before receiving an Assistive Telecommunication Device or Adaptive Equipment, a recipient must sign the Conditions of Acceptance. A recipient who received TDAP equipment when under the age of 18 must sign a new Conditions of Acceptance form within 30 calendar days after becoming 18 years of age. Similarly, if there is a change in legal guardian for an adult recipient, the new guardian must sign a Conditions of Acceptance form within 30 calendar days of the change in guardianship. Failure to do so will result in the Commission billing the parent or guardian of record for the device.

(3) Before the requested equipment is distributed, an applicant or recipient must pay in full all outstanding accounts with the Commission.

(4) Any Assistive Telecommunication Device or Adaptive Equipment distributed to an eligible recipient under this program may not be sold, loaned, or otherwise transferred from the possession of the original recipient. Unauthorized transfers subject the recipient to repossession of the Assistive Telecommunication Device or Adaptive Equipment, prosecution, or liability for the full purchase price of the equipment.

(5) A recipient who moves to a different address within Oregon must report the new address to the Commission within 30 calendar days of the move. A recipient who moves out of Oregon must return all Assistive Telecommunication Devices or Adaptive Equipment received through the Commission to an Authorized Distributor or the Commission before moving out of Oregon. A recipient who is no longer receiving telephone services must return all Assistive Telecommunication Devices or Adaptive Equipment received through the Commission to an Authorized Distributor or the Commission within 30 calendar days after termination of Local Exchange Service.

(6) A recipient may take Assistive Telecommunication Devices or Adaptive Equipment on travel outside Oregon. The recipient must obtain written permission from the Commission if the travel will be for more than 90 calendar days.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290
Hist.: PUC 7-1988, f. & cert. ef. 4-6-88 (Order No. 88-339); PUC 5-1992, f. & cert. ef. 2-14-92 (Order No. 92-238); PUC 18-1997, f. & cert. ef. 12-17-97 860-033-0535(5) Renumbered to 860-033-0536; PUC 12-1999, f. & cert. ef. 11-18-99; PUC 19-2003, f. & cert. ef. 11-14-03; PUC 16-2004, f. & cert. ef. 12-1-04; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13

860-033-0536
TDAP Recipients' Liability

(1) The recipient is financially responsible for any damage to the equipment that is not caused by normal wear and tear, acts of nature, or disasters. To avoid financial responsibility for damaged equipment, the recipient must prove to the Commission that the damage was caused by normal wear and tear or acts of nature or disasters. The recipient is also financially responsible for the full replacement cost of the equipment if the recipi-

ent loses the equipment or moves out of Oregon without returning the equipment.

(2) Stolen Equipment or Equipment Damaged by Acts of Nature or Disasters:

(a) If the equipment is stolen, a recipient must notify the local law enforcement agency within 24 hours of the time the recipient discovers the theft. A recipient must forward a copy of the police report to the Commission within five business days of the date the theft was reported. If the local law enforcement agency does not respond to the recipient's theft report, the recipient must notify the Commission within five business days after the theft was reported. The recipient must forward a written report to the Commission that describes the theft and includes any witnesses' names, addresses, and telephone numbers.

(b) If the equipment is stolen outside the United States, the recipient must submit a copy of the police report to the Commission within five business days of the date the theft was reported. If the local law enforcement agency does not respond to the recipient's theft report, the recipient must notify the Commission within five business days after returning to Oregon. The recipient must forward to the Commission a written report that includes any witnesses' names, addresses, and telephone numbers; and describes the theft.

(c) If the equipment is damaged due to acts of nature or disasters, including, but not limited to floods, storms or fire, the recipient must submit an insurance claim, fire department report, police report, or other equivalent documentation about the event within five business days after the date the event occurred.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290
Hist.: PUC 7-1988, f. & cert. ef. 4-6-88 (Order No. 88-339); PUC 5-1992, f. & cert. ef. 2-14-92 (Order No. 92-238); PUC 18-1997, f. & cert. ef. 12-17-97 Renumbered from 860-033-0535(5); PUC 19-2003, f. & cert. ef. 11-14-03; PUC 16-2004, f. & cert. ef. 12-1-04; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13

860-033-0537
Holding Recipients Financially Responsible for Damaged, Lost, or Otherwise Not Returned Assistive Telecommunication Devices or Adaptive Equipment

(1) Invoices:

(a) The Commission will mail an invoice indicating the amount of and the reason for such invoice to the responsible recipient at the last known address. The recipient has 30 calendar days from the service date of the invoice to respond.

(b) The invoiced recipient may submit a written response to the Commission in an attempt to resolve the invoice. At the Commission's discretion, further investigation may be initiated. If the investigation finds that the invoice was issued in error (for example, there is no verifiable reason for the invoice having been sent), the invoice may be canceled.

(c) If the Commission does not receive payment, the Commission may begin the collection activities.

(d) Incorrect address: When an invoice or notice of proposed assessment is returned with an incorrect address and the invoiced recipient has not notified the Commission of an address change as required by the Conditions of Acceptance for TDAP Equipment, the amount billed to the recipient becomes a liquidated debt.

(2) Notice of Proposed Assessment:

(a) If the recipient does not respond to the invoice within 30 days from the service date of the invoice, the Commission may issue a written proposed assessment for the amount due.

(b) The recipient may pay the assessment in full within 30 days of the service date of the notice of proposed assessment or may file a written petition for a hearing within 30 days of the service date of the notice of proposed assessment. A written petition for a hearing must clearly specify all the reasons the recipient disputes the proposed assessments.

(A) If the recipient pays the proposed assessment in full within the 30 days of the service date of the notice of proposed assessment, the Commission will accept the payment and discontinue any further collection activities for that assessment.

(B) If the recipient timely files a written petition for a hearing as set forth in subsection (b) of this section of this rule, the Commission will grant the recipient a hearing and give at least 10 days notice of the time and place of the hearing. The Commission will conduct the hearing under its rules governing hearings and proceedings.

(3) Commission Order:

(a) The Commission will enter an order if the recipient does not respond to the notice of proposed assessment within 30 days of the service date of the notice of proposed assessment or after considering the testimony presented at hearing. Any charges assessed by the Commission in its order become due and payable on the tenth day after the service date of the Commission's order.

(b) If the recipient does not respond to the order assessing charges, the account may be referred to the Department of Revenue or a collection agency for collection. The recipient is responsible for and must pay all costs incurred by the Commission to collect a past-due invoice amount from the recipient.

(4) Collection procedures for a recipient with two or more Assistive Telecommunication Devices or Adaptive Equipment units:

(a) The Commission will mail a letter to the recipient asking the recipient to return the equipment within 30 calendar days, and

(b) If the Commission does not receive a response, the Commission will send an invoice to the recipient. If the recipient does not pay the amount billed, the Commission may take the necessary action against the recipient to either regain possession of the State of Oregon's equipment or receive the full replacement value of such equipment.

(5) When the Commission receives notice that a recipient is deceased, the Commission will request that the estate return the equipment. The Commission may bill the estate for the cost of replacing the equipment if it has not been returned, or if it is returned in damaged condition.

(6) If the lost, damaged, or otherwise not returned equipment is obsolete or is no longer offered by the TDAP, the Commission may waive the recipient's financial responsibility.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290
Hist.: PUC 18-1997, f. & cert. ef. 12-17-97; PUC 12-1999, f. & cert. ef. 11-18-99; PUC 19-2003, f. & cert. ef. 11-14-03; PUC 16-2004, f. & cert. ef. 12-1-04; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 9-2011, f. & cert. ef. 10-4-11; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13

860-033-0540
Distribution Procedures for Assistive Telecommunication Devices or Adaptive Equipment

(1) Subject to appropriation and approval of expenditures for Assistive Telecommunication Devices or Adaptive Equipment and services purchased by the Commission, the Commission may contract with any governmental agency or other entity to establish an Authorized Distributor network and an Authorized Maintenance Center network.

(2) If demand exceeds supply, the Commission may distribute Assistive Telecommunication Devices or Adaptive Equipment to customers on a first-come first-serve basis.

(3) Each Authorized Distributor must inform the Commission in writing of all incoming and outgoing shipments of Assistive Telecommunication Devices or Adaptive Equipment. The written information must include the serial numbers engraved by the Authorized Distributor.

(4) Upon notice from the Commission, the Authorized Distributor must distribute Assistive Telecommunication Devices or Adaptive Equipment to eligible applicants.

(5) The Authorized Distributor must require each recipient, including the parent or legal guardian, to sign the Conditions of Acceptance form supplied by the Commission before providing an Assistive Telecommunication Device or Adaptive Equipment unit. The Authorized Distributor and Authorized Maintenance Center must forward all forms to the Commission.

(6) If needed, the Commission may contract with an agency or individual to provide training on Assistive Telecommunication Devices or Adaptive Equipment to specialized populations.

(7) Recipients of Assistive Telecommunication Devices or Adaptive Equipment are responsible for replacement paper for the Assistive Telecommunication Device or Adaptive Equipment, the payment of the recipient's monthly telephone bill, the purchase or lease cost of recipient's telephone, the cost of replacement light bulbs for signal devices and batteries for the equipment.

(8) The Commission may require the Authorized Distributor to provide each recipient a copy of the OTAP application form, mailing forms for purchasing TTY paper, and telecommunications relay service information handouts.

(9) The recipient must return defective or damaged equipment to the Commission, at the Commission's expense, prior to receiving repaired or replacement equipment. The Commission will decide whether to replace or to repair the damaged or defective equipment. The requirement to return defective or damaged equipment prior to receiving repaired or replaced equipment may be waived by the Commission.

Stat. Auth.: ORS 183, 756, 759 & 1987 OL Ch. 290
Stats. Implemented: ORS 756.040, 759.036 & 1987 OL Ch. 290
Hist.: PUC 7-1988, f. & cert. ef. 4-6-88 (Order No. 88-339); PUC 18-1989, f. & cert. ef. 12-14-89 (Order No. 89-1602); PUC 5-1992, f. & cert. ef. 2-14-92 (Order No. 92-238); PUC 18-1997, f. & cert. ef. 12-17-97; PUC 12-1999, f. & cert. ef. 11-18-99; PUC 16-2004, f. & cert.

ef. 12-1-04; PUC 12-2009, f. & cert. ef. 11-13-09; PUC 5-2013(Temp), f. & cert. ef. 6-28-13 thru 12-24-13

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Public Utility Commission,
Board of Maritime Pilots
Chapter 856

Rule Caption: Adjusts pilot license fee by percentage change in consumer price index for previous 24 months
Adm. Order No.: BMP 2-2013
Filed with Sec. of State: 7-1-2013
Certified to be Effective: 7-1-13
Notice Publication Date: 6-1-2013
Rules Amended: 856-010-0016
Subject: The Board is statutorily required to adjust the amount of the maximum annual license fee for a maritime pilot for each subsequent biennium by a proportional amount equal to the percentage change in the 24-month period prior to the beginning of the biennium in the Portland-Salem, OR-WA, Consumer Price Index for All Urban Consumers for All Items, as published by the Bureau of Labor Statistics of the United States Department of Labor. The cumulative CPI for the previous period will increase the license fee from $2,718 to $2,858 annually.
Rules Coordinator: Susan Johnson—(971) 673-1530

856-010-0016
License Fees

The annual license fee for pilots shall be $2,858.

Stat. Auth.: ORS 776
Stats. Implemented: ORS 776.115 & 776.355
Hist.: MP 1-1991(Temp), f. 6-19-91, cert. ef. 7-1-91; MP 2-1991, f. & cert. ef. 12-27-91; MP 3-1992(Temp), f. 6-26-92, cert. ef. 7-1-92; MP 4-1992, f. 11-13-92, cert. ef. 12-28-92; BMP 3-2007(Temp), f. & cert. ef. 7-26-07 thru 1-21-08; BMP 1-2008, f. & cert. ef. 1-24-08; BMP 6-2009, f. & cert. ef. 8-24-09; BMP 6-2011, f. 10-31-11, cert. ef. 11-1-11; BMP 2-2013, f. & cert. ef. 7-1-13

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Secretary of State,
Elections Division
Chapter 165

Rule Caption: Criminal History Record for Paid Circulators
Adm. Order No.: ELECT 5-2013(Temp)
Filed with Sec. of State: 7-10-2013
Certified to be Effective: 7-10-13 thru 1-6-14
Notice Publication Date:
Rules Adopted: 165-014-0148
Subject: This rule requires any person who will be paid to gather signatures on a state initiative, referendum, recall or prospective petition to submit their Criminal History Report as provided by the Oregon State Police Open Records Section when registering as a circulator. Chief petitioners or their authorized agent(s) may coordinate the circulators criminal history record check and facilitate the filing of the complete registration. Additionally the rule provides that any incomplete registration will be rejected and returned to the filer.
Rules Coordinator: Brenda Bayes—(503) 986-1518

165-014-0148
Criminal History Report

(1) In addition to the registration requirements set forth in OAR 165-014-0280 any person who will be paid to gather signatures on a state initiative, referendum, recall or prospective petition must submit a copy of their Criminal History Report provided by the Oregon State Police Open Records Section.

(2) Chief petitioners or their authorized agent(s) may coordinate circulators criminal history record check and facilitate the filing of a circulators complete registration.

(3) A complete registration includes:

(a) SEL 308 Circulator Registration;

(b) SEL 306 Circulator Registration Training Certificate;

(c) SEL 309 Chief Petitioner Acknowledgment;

(d) Digital photograph of circulator that is less than four years old when filed, portrait style, front-facing, showing the face, neck and shoulders only; and

(e) Criminal History Report provided by the Oregon State Police Open Records Section.

(4) The Elections Division will reject any registration that does not contain all materials listed in paragraph (3) of this rule and return the material submitted to the filer.

Stat. Auth.: 2013 OL Ch. 519
Stats. Implemented: ORS 246.150 & 2013 OL Ch. 519
Hist.: ELECT 5-2013(Temp), f. & cert. ef. 7-10-13 thru 1-6-14

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Water Resources Department
Chapter 690

Rule Caption: Temporary Rule Granting Preference to Stock Watering and Human Consumption water use in Klamath County
Adm. Order No.: WRD 1-2013(Temp)
Filed with Sec. of State: 7-1-2013
Certified to be Effective: 7-1-13 thru 12-27-13
Notice Publication Date:
Rules Adopted: 690-022-0005, 690-022-0010, 690-022-0015
Subject: Oregon Governor Kitzhaber declared a drought in Klamath County under Executive Order No. 13-05 on April 18, 2013. ORS 536.750 authorizes the Oregon Water Resources Commission, pursuant to a gubernatorial declaration of drought, to grant preference of water use for human consumption and stock watering over other uses of water regardless of priority date. Without the preference the use of water for human consumption and stock watering would be subject to regulation, and as a result, surface water that would otherwise be used to meet these needs may not be available. For some water users, there are no readily available alternative sources of water for either stock watering or human consumption. These rules propose to grant a preference for the use of water for stock watering and human consumption in Klamath County for a period of 180 days or for the duration of the declared drought, whichever is shorter.
Rules Coordinator: Ruben Ochoa—(503) 986-0874

690-022-0005
Purpose and Statutory Authority

(1) The purpose of these rules is to implement ORS 536.750(1)(c), which authorizes the Commission, pursuant to a gubernatorial declaration that a severe, continuing drought exists, to grant a temporary preference to water rights for human consumption or stock watering use over other water uses regardless of priority date. These rules address an immediate threat to the health and welfare of the people of Oregon that would otherwise occur if regulation of senior water rights in Klamath County curtailed or prohibited use of surface water for human consumption and stock watering as defined in these rules.

(2) Executive Order No. 13 – 05: Determination of a State of Drought Emergency in Klamath County Due to Drought and Low Water Conditions, was signed by Governor John A. Kitzhaber, M.D., on April 18, 2013.

(3) These rules become effective on July 1, 2013 and will remain in effect for 180 days from the effective date or for the term of Oregon Governor Kitzhaber's Executive Order No. 13 – 05, whichever is shorter.

Stat. Auth.: ORS 536.025, 536.027 & 536.750
Stats. Implemented: ORS 536.750
Hist.: WRD 1-2013(Temp), f. & cert. ef. 7-1-13 thru 12-27-13

690-022-0010
Definitions

The words and phrases used in division 22 have the following meaning:

(1) "Commission" means the Oregon Water Resources Commission.

(2) "Department" means the Oregon Water Resources Department.

(3) "Human Consumption" means the use of water for the purposes of drinking, cooking, and sanitation.

(4) "Stock Watering Use" means the use of water for consumption by domesticated animals and wild animals held in captivity as pets or for profit.

Stat. Auth.: ORS 536.025, 536.027 & 536.750
Stats. Implemented: ORS 536.750
Hist.: WRD 1-2013(Temp), f. & cert. ef. 7-1-13 thru 12-27-13

690-022-0015
Applicability and Preference

Notwithstanding any provision of Oregon Administrative Rules division 690 to the contrary: These rules apply only to the diversion or use of surface water within Klamath County.

(1) Uses of surface water for human consumption and stock watering, to the extent authorized under a water right certificate, permit, decree, or findings of fact and order of determination issued in an adjudication subject to ORS Chapter 539, are granted a preference over all other water uses regardless of the priority date of the underlying water right.

(2) The Department will regulate water rights in Klamath County in accordance with the preference for water rights for human consumption and stock watering use granted in 690-022-0015(2) of these rules.

(3) Political subdivisions exercising the human consumption or stock water preferences established in this rule shall assure curtailment of water uses unrelated to the preference consistent with this rule.

Stat. Auth.: ORS 536.025; 536.027; 536.750
Stats. Implemented: ORS 536.750
Hist.: WRD 1-2013(Temp), f. & cert. ef. 7-1-13 thru 12-27-13

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150-309.110	1-1-2013	Repeal	2-1-2013
150-309.110	3-28-2013	Repeal	5-1-2013
150-311.668(1)(a)-(A)	1-1-2013	Repeal	2-1-2013
150-311.668(1)(a)-(B)	1-1-2013	Repeal	2-1-2013
150-311.668(1)(a)(A)	3-28-2013	Repeal	5-1-2013
150-311.668(1)(a)(B)	3-28-2013	Repeal	5-1-2013
150-311.670(1)	1-1-2013	Amend	2-1-2013
150-311.670(1)	3-28-2013	Amend	5-1-2013
150-311.679(10)	1-1-2013	Repeal	2-1-2013
150-311.679(10)	3-28-2013	Repeal	5-1-2013
150-311.684	1-1-2013	Amend	2-1-2013
150-311.684	3-28-2013	Amend	5-1-2013
150-311.706	1-1-2013	Repeal	2-1-2013
150-311.706	3-28-2013	Repeal	5-1-2013
150-311.706(1)	1-1-2013	Repeal	2-1-2013
150-311.706(1)	3-28-2013	Repeal	5-1-2013
150-311.806-(A)	1-1-2013	Amend	2-1-2013
150-311.806-(A)	3-28-2013	Amend	5-1-2013
150-314.781	1-1-2013	Amend	2-1-2013
150-314.781	3-28-2013	Amend	5-1-2013
150-315.068	6-5-2013	Amend(T)	7-1-2013
150-316.871(3)	1-1-2013	Repeal	2-1-2013
150-316.871(3)	3-28-2013	Repeal	5-1-2013
150-316.873	1-1-2013	Repeal	2-1-2013
150-316.873	3-28-2013	Repeal	5-1-2013
150-316.874	1-1-2013	Repeal	2-1-2013
150-316.874	3-28-2013	Repeal	5-1-2013
150-316.876	1-1-2013	Repeal	2-1-2013
150-316.876	3-28-2013	Repeal	5-1-2013
150-316.877	1-1-2013	Repeal	2-1-2013
150-316.877	3-28-2013	Repeal	5-1-2013
150-316.878	1-1-2013	Repeal	2-1-2013
150-316.878	3-28-2013	Repeal	5-1-2013
150-316.879	1-1-2013	Repeal	2-1-2013
150-316.879	3-28-2013	Repeal	5-1-2013
150-316.882	1-1-2013	Repeal	2-1-2013
150-316.882	3-28-2013	Repeal	5-1-2013
150-316.884	1-1-2013	Repeal	2-1-2013
150-316.884	3-28-2013	Repeal	5-1-2013
150-323.160(1)	1-1-2013	Amend	2-1-2013
150-323.160(1)	3-28-2013	Amend	5-1-2013
150-323.160(2)	1-1-2013	Amend	2-1-2013
150-323.160(2)	3-28-2013	Amend	5-1-2013
150-323.220-(A)	1-1-2013	Amend	2-1-2013
150-323.220-(B)	1-1-2013	Adopt	2-1-2013
150-323.220(A)	3-28-2013	Amend	5-1-2013
150-323.220(B)	3-28-2013	Adopt	5-1-2013
150-457.440(9)	7-15-2013	Amend(T)	8-1-2013
161-002-0000	1-31-2013	Amend	3-1-2013
161-003-0020	1-31-2013	Amend	3-1-2013
161-006-0025	1-31-2013	Amend	3-1-2013
161-006-0025	7-1-2013	Amend(T)	7-1-2013
161-006-0155	1-31-2013	Adopt	3-1-2013
161-006-0160	1-31-2013	Amend	3-1-2013
161-010-0010	1-31-2013	Amend	3-1-2013
161-010-0020	1-31-2013	Amend	3-1-2013
161-010-0035	1-31-2013	Amend	3-1-2013
161-010-0045	1-31-2013	Amend	3-1-2013
161-010-0065	1-31-2013	Adopt	3-1-2013
161-010-0080	1-31-2013	Amend	3-1-2013
161-010-0080	7-1-2013	Amend(T)	8-1-2013
161-015-0000	1-31-2013	Amend	3-1-2013
161-015-0010	1-31-2013	Amend	3-1-2013
161-015-0025	1-31-2013	Amend	3-1-2013
161-015-0025	7-1-2013	Amend(T)	8-1-2013
161-015-0030	1-31-2013	Amend	3-1-2013
161-015-0030	7-1-2013	Amend(T)	8-1-2013
161-020-0005	1-31-2013	Amend	3-1-2013
161-020-0055	1-31-2013	Amend	3-1-2013
161-020-0110	1-31-2013	Amend	3-1-2013
161-025-0025	1-31-2013	Amend	3-1-2013
161-025-0030	1-31-2013	Amend	3-1-2013
161-025-0050	1-31-2013	Amend	3-1-2013
161-050-0000	1-31-2013	Amend	3-1-2013
161-050-0040	1-31-2013	Amend	3-1-2013
161-050-0050	1-31-2013	Amend	3-1-2013
161-050-0050	7-1-2013	Suspend	8-1-2013
161-510-0010	1-31-2013	Amend	3-1-2013
161-510-0030	1-31-2013	Repeal	3-1-2013
161-520-0010	1-31-2013	Amend	3-1-2013
161-520-0030	1-31-2013	Amend	3-1-2013
161-520-0035	1-31-2013	Adopt	3-1-2013
161-520-0045	1-31-2013	Amend	3-1-2013
161-520-0050	1-31-2013	Amend	3-1-2013
161-530-0010	1-31-2013	Amend	3-1-2013
161-570-0025	1-31-2013	Adopt	3-1-2013

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161-570-0055	1-31-2013	Adopt	3-1-2013
161-570-0060	1-31-2013	Adopt	3-1-2013
162-050-0020	11-27-2012	Adopt	1-1-2013
165-013-0010	2-4-2013	Amend	3-1-2013
165-014-0148	7-10-2013	Adopt(T)	8-1-2013
165-018-0005	6-4-2013	Repeal	7-1-2013
165-018-0010	6-4-2013	Repeal	7-1-2013
165-018-0015	6-4-2013	Repeal	7-1-2013
165-018-0020	6-4-2013	Repeal	7-1-2013
165-018-0030	6-4-2013	Repeal	7-1-2013
165-020-0050	6-4-2013	Amend	7-1-2013
165-020-0060	6-4-2013	Repeal	7-1-2013
165-020-0440	11-29-2012	Adopt	1-1-2013
165-020-2032	3-19-2013	Adopt(T)	5-1-2013
170-040-0020	4-2-2013	Amend	5-1-2013
170-040-0030	4-2-2013	Amend	5-1-2013
170-040-0040	4-2-2013	Amend	5-1-2013
170-040-0050	4-2-2013	Amend	5-1-2013
170-040-0070	4-2-2013	Amend	5-1-2013
170-040-0080	4-2-2013	Amend	5-1-2013
170-040-0090	4-2-2013	Amend	5-1-2013
170-040-0100	4-2-2013	Amend	5-1-2013
170-040-0110	4-2-2013	Amend	5-1-2013
170-061-0015	12-14-2012	Amend(T)	1-1-2013
170-061-0015	4-24-2013	Amend	6-1-2013
170-062-0000	11-19-2012	Amend(T)	1-1-2013
173-006-0005	7-1-2013	Amend(T)	7-1-2013
173-008-0005	7-1-2013	Amend(T)	7-1-2013
177-010-0003	2-1-2013	Amend(T)	3-1-2013
177-010-0003	7-1-2013	Amend	8-1-2013
177-010-0003(T)	7-1-2013	Repeal	8-1-2013
177-010-0003(T)	7-1-2013	Repeal	8-1-2013
177-040-0017	1-1-2013	Amend	2-1-2013
177-040-0050	2-1-2013	Amend(T)	3-1-2013
177-040-0050	7-1-2013	Amend	8-1-2013
177-040-0050(T)	7-1-2013	Repeal	8-1-2013
177-040-0050(T)	7-1-2013	Repeal	8-1-2013
177-040-0200	2-1-2013	Amend(T)	3-1-2013
177-040-0200	7-1-2013	Amend	8-1-2013
177-040-0200	7-1-2013	Amend	8-1-2013
177-040-0200(T)	7-1-2013	Repeal	8-1-2013
177-040-0200(T)	7-1-2013	Repeal	8-1-2013
177-046-0015	2-1-2013	Amend(T)	3-1-2013
177-046-0015	7-1-2013	Amend	8-1-2013
177-046-0015(T)	7-1-2013	Repeal	8-1-2013
177-046-0015(T)	7-1-2013	Repeal	8-1-2013
177-046-0080	2-1-2013	Amend(T)	3-1-2013
177-046-0080	7-1-2013	Amend	8-1-2013
177-046-0080(T)	7-1-2013	Repeal	8-1-2013
177-046-0080(T)	7-1-2013	Repeal	8-1-2013
177-046-0100	2-1-2013	Amend(T)	3-1-2013
177-046-0100	7-1-2013	Amend	8-1-2013
177-046-0100(T)	7-1-2013	Repeal	8-1-2013
177-046-0100(T)	7-1-2013	Repeal	8-1-2013
177-046-0110	2-1-2013	Amend(T)	3-1-2013
177-046-0110	7-1-2013	Amend	8-1-2013
177-046-0110(T)	7-1-2013	Repeal	8-1-2013
177-046-0110(T)	7-1-2013	Repeal	8-1-2013
177-046-0140	2-1-2013	Amend(T)	3-1-2013
177-046-0140	7-1-2013	Amend	8-1-2013
177-046-0140(T)	7-1-2013	Repeal	8-1-2013
177-046-0140(T)	7-1-2013	Repeal	8-1-2013
177-050-0002	2-1-2013	Amend(T)	3-1-2013
177-050-0002	7-1-2013	Amend	8-1-2013
177-050-0002(T)	7-1-2013	Repeal	8-1-2013
177-050-0024	2-1-2013	Amend(T)	3-1-2013
177-050-0024	7-1-2013	Amend	8-1-2013
177-050-0024(T)	7-1-2013	Repeal	8-1-2013
177-050-0025	2-1-2013	Amend(T)	3-1-2013
177-050-0025	7-1-2013	Amend	8-1-2013
177-050-0025(T)	7-1-2013	Repeal	8-1-2013
177-050-0100	2-1-2013	Amend(T)	3-1-2013
177-050-0100	7-1-2013	Amend	8-1-2013
177-050-0100(T)	7-1-2013	Repeal	8-1-2013
177-051-0000	2-1-2013	Amend(T)	3-1-2013
177-051-0000	7-1-2013	Amend	8-1-2013
177-051-0000(T)	7-1-2013	Repeal	8-1-2013
177-051-0010	2-1-2013	Amend(T)	3-1-2013
177-051-0010	7-1-2013	Amend	8-1-2013
177-051-0010(T)	7-1-2013	Repeal	8-1-2013
177-051-0030	2-1-2013	Amend(T)	3-1-2013
177-051-0030	7-1-2013	Amend	8-1-2013
177-051-0030(T)	7-1-2013	Repeal	8-1-2013
177-051-0030(T)	7-1-2013	Repeal	8-1-2013
177-051-0035	2-1-2013	Amend(T)	3-1-2013
177-051-0035	7-1-2013	Amend	8-1-2013
177-051-0035	7-1-2013	Amend	8-1-2013
177-051-0035(T)	7-1-2013	Repeal	8-1-2013
177-051-0040	2-1-2013	Amend(T)	3-1-2013
177-051-0040	7-1-2013	Amend	8-1-2013
177-051-0040(T)	7-1-2013	Repeal	8-1-2013
177-051-0120	2-1-2013	Amend(T)	3-1-2013
177-051-0120	7-1-2013	Amend	8-1-2013
177-051-0120(T)	7-1-2013	Repeal	8-1-2013
177-051-0130	2-1-2013	Amend(T)	3-1-2013
177-051-0130	7-1-2013	Amend	8-1-2013
177-051-0130(T)	7-1-2013	Repeal	8-1-2013
177-052-0000	2-1-2013	Amend(T)	3-1-2013
177-052-0000	7-1-2013	Amend	8-1-2013
177-052-0000(T)	7-1-2013	Repeal	8-1-2013
177-052-0010	2-1-2013	Amend(T)	3-1-2013
177-052-0010	7-1-2013	Amend	8-1-2013
177-052-0010	7-1-2013	Amend	8-1-2013
177-052-0010(T)	7-1-2013	Repeal	8-1-2013
177-052-0020	2-1-2013	Amend(T)	3-1-2013
177-052-0020	7-1-2013	Amend	8-1-2013
177-052-0020	7-1-2013	Amend	8-1-2013
177-052-0020(T)	7-1-2013	Repeal	8-1-2013
177-052-0030	2-1-2013	Amend(T)	3-1-2013
177-052-0030	7-1-2013	Amend	8-1-2013

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177-052-0030(T)	7-1-2013	Repeal	8-1-2013
177-052-0040	2-1-2013	Amend(T)	3-1-2013
177-052-0040	7-1-2013	Amend	8-1-2013
177-052-0040	7-1-2013	Amend	8-1-2013
177-052-0040(T)	7-1-2013	Repeal	8-1-2013
177-052-0050	2-1-2013	Amend(T)	3-1-2013
177-052-0050	7-1-2013	Amend	8-1-2013
177-052-0050	7-1-2013	Amend	8-1-2013
177-052-0050(T)	7-1-2013	Repeal	8-1-2013
177-052-0060	2-1-2013	Amend(T)	3-1-2013
177-052-0060	7-1-2013	Amend	8-1-2013
177-052-0060	7-1-2013	Amend	8-1-2013
177-052-0060(T)	7-1-2013	Repeal	8-1-2013
177-052-0070	2-1-2013	Amend(T)	3-1-2013
177-052-0070	7-1-2013	Amend	8-1-2013
177-052-0070	7-1-2013	Amend	8-1-2013
177-052-0070(T)	7-1-2013	Repeal	8-1-2013
177-070-0005	2-1-2013	Amend(T)	3-1-2013
177-070-0005	7-1-2013	Amend	8-1-2013
177-070-0005	7-1-2013	Amend	8-1-2013
177-070-0005(T)	7-1-2013	Repeal	8-1-2013
177-094-0080	12-16-2012	Amend	1-1-2013
177-094-0080(T)	12-16-2012	Repeal	1-1-2013
177-094-0085	12-16-2012	Amend	1-1-2013
177-094-0085(T)	12-16-2012	Repeal	1-1-2013
230-020-0002	4-15-2013	Amend(T)	5-1-2013
230-020-0002	7-10-2013	Amend(T)	8-1-2013
230-020-0330	2-21-2013	Amend	4-1-2013
230-020-0330	7-10-2013	Amend(T)	8-1-2013
230-020-0330	7-10-2013	Amend(T)	8-1-2013
250-020-0141	4-1-2013	Amend	5-1-2013
250-020-0221	4-12-2013	Amend(T)	5-1-2013
250-020-0280	5-8-2013	Amend(T)	6-1-2013
250-020-0280	6-28-2013	Amend	8-1-2013
250-020-0280	7-1-2013	Amend(T)	8-1-2013
250-020-0280	7-1-2013	Amend(T)	8-1-2013
250-020-0280(T)	6-28-2013	Repeal	8-1-2013
255-030-0010	3-1-2013	Amend	4-1-2013
255-030-0013	3-1-2013	Amend	4-1-2013
255-030-0021	3-1-2013	Amend	4-1-2013
255-030-0023	3-1-2013	Amend	4-1-2013
255-030-0024	3-1-2013	Amend	4-1-2013
255-030-0025	3-1-2013	Amend	4-1-2013
255-030-0025	6-10-2013	Amend	7-1-2013
255-030-0026	3-1-2013	Amend	4-1-2013
255-030-0026	6-10-2013	Amend	7-1-2013
255-030-0027	3-1-2013	Amend	4-1-2013
255-030-0032	3-1-2013	Amend	4-1-2013
255-030-0035	3-1-2013	Amend	4-1-2013
255-030-0040	3-1-2013	Amend	4-1-2013
255-030-0046	3-1-2013	Adopt	4-1-2013
255-030-0055	3-1-2013	Amend	4-1-2013
255-060-0011	6-25-2013	Amend	8-1-2013
255-060-0016	6-25-2013	Amend	8-1-2013
255-062-0016	2-15-2013	Amend	3-1-2013
259-005-0015	4-1-2013	Amend	5-1-2013
259-008-0005	12-27-2012	Amend	2-1-2013
259-008-0025	3-8-2013	Amend	4-1-2013
259-008-0025	6-25-2013	Amend	8-1-2013
259-008-0060	12-27-2012	Amend	2-1-2013
259-008-0064	12-27-2012	Amend	2-1-2013
259-008-0065	12-27-2012	Amend	2-1-2013
259-008-0066	12-27-2012	Amend	2-1-2013
259-008-0067	6-5-2013	Amend(T)	7-1-2013
259-008-0070	12-14-2012	Amend(T)	1-1-2013
259-008-0070	1-22-2013	Amend	3-1-2013
259-008-0070(T)	1-22-2013	Repeal	3-1-2013
259-008-0075	6-24-2013	Amend	8-1-2013
259-008-0076	12-27-2012	Amend	2-1-2013
259-008-0100	6-24-2013	Amend	8-1-2013
259-009-0005	3-26-2013	Amend	5-1-2013
259-009-0062	3-26-2013	Amend	5-1-2013
259-009-0062	6-25-2013	Amend	8-1-2013
259-009-0070	3-26-2013	Amend	5-1-2013
259-009-0080	3-26-2013	Amend	5-1-2013
259-012-0005	1-24-2013	Amend	3-1-2013
259-015-0000	1-30-2013	Repeal	3-1-2013
259-015-0005	1-30-2013	Repeal	3-1-2013
259-015-0010	1-30-2013	Repeal	3-1-2013
259-020-0010	12-26-2012	Amend	2-1-2013
259-020-0015	12-26-2012	Amend	2-1-2013
259-020-0030	12-26-2012	Amend	2-1-2013
259-020-0031	12-26-2012	Repeal	2-1-2013
259-060-0010	12-24-2012	Amend	2-1-2013
259-060-0010	6-24-2013	Amend	8-1-2013
259-060-0015	12-24-2012	Amend	2-1-2013
259-060-0015	6-24-2013	Amend	8-1-2013
259-060-0020	6-24-2013	Amend	8-1-2013
259-060-0025	6-24-2013	Amend	8-1-2013
259-060-0030	6-24-2013	Amend	8-1-2013
259-060-0060	6-24-2013	Amend	8-1-2013
259-060-0090	6-24-2013	Amend	8-1-2013
259-060-0120	6-24-2013	Amend	8-1-2013
259-060-0135	6-24-2013	Amend	8-1-2013
259-060-0300	6-24-2013	Amend	8-1-2013
259-060-0450	6-24-2013	Amend	8-1-2013
259-060-0500	6-24-2013	Amend	8-1-2013
259-060-0600	12-26-2012	Amend	2-1-2013
259-061-0010	1-2-2013	Amend	2-1-2013
259-061-0015	1-2-2013	Repeal	2-1-2013
259-061-0020	1-2-2013	Amend	2-1-2013
259-061-0020	6-24-2013	Amend	8-1-2013
259-061-0030	1-2-2013	Repeal	2-1-2013
259-061-0050	1-2-2013	Repeal	2-1-2013
259-061-0055	1-2-2013	Repeal	2-1-2013
259-061-0060	1-2-2013	Repeal	2-1-2013
259-061-0070	1-2-2013	Repeal	2-1-2013
259-061-0080	1-2-2013	Repeal	2-1-2013
259-061-0090	1-2-2013	Repeal	2-1-2013
259-070-0020	12-24-2012	Amend	2-1-2013
274-001-0005	5-15-2013	Amend	6-1-2013

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274-015-0010	7-9-2013	Amend(T)	8-1-2013
274-020-0200	7-8-2013	Amend	8-1-2013
274-045-0001	7-8-2013	Amend	8-1-2013
291-013-0010	6-21-2013	Amend	8-1-2013
291-013-0055	6-21-2013	Amend	8-1-2013
291-013-0070	6-21-2013	Amend	8-1-2013
291-013-0104	6-21-2013	Amend	8-1-2013
291-013-0110	6-21-2013	Amend	8-1-2013
291-013-0130	6-21-2013	Amend	8-1-2013
291-013-0140	6-21-2013	Amend	8-1-2013
291-013-0206	6-21-2013	Amend	8-1-2013
291-013-0215	6-21-2013	Amend	8-1-2013
291-053-0010	1-17-2013	Amend	3-1-2013
291-053-0075	1-17-2013	Amend	3-1-2013
291-053-0085	1-17-2013	Amend	3-1-2013
291-053-0095	1-17-2013	Amend	3-1-2013
291-053-0105	1-17-2013	Amend	3-1-2013
291-053-0115	1-17-2013	Amend	3-1-2013
291-053-0125	1-17-2013	Amend	3-1-2013
291-053-0135	1-17-2013	Amend	3-1-2013
291-078-0005	2-28-2013	Amend	4-1-2013
291-078-0005(T)	2-28-2013	Repeal	4-1-2013
291-078-0010	2-28-2013	Amend	4-1-2013
291-078-0010(T)	2-28-2013	Repeal	4-1-2013
291-078-0020	2-28-2013	Amend	4-1-2013
291-078-0020(T)	2-28-2013	Repeal	4-1-2013
291-078-0026	2-28-2013	Adopt	4-1-2013
291-078-0026(T)	2-28-2013	Repeal	4-1-2013
291-078-0031	2-28-2013	Adopt	4-1-2013
291-078-0031(T)	2-28-2013	Repeal	4-1-2013
291-093-0005	4-15-2013	Amend	5-1-2013
291-097-0005	12-28-2012	Am. & Ren.(T)	2-1-2013
291-097-0005	6-1-2013	Am. & Ren.	7-1-2013
291-097-0010	12-28-2012	Am. & Ren.(T)	2-1-2013
291-097-0010	6-1-2013	Am. & Ren.	7-1-2013
291-097-0015	12-28-2012	Am. & Ren.(T)	2-1-2013
291-097-0015	6-1-2013	Am. & Ren.	7-1-2013
291-097-0020	12-28-2012	Am. & Ren.(T)	2-1-2013
291-097-0020	6-1-2013	Am. & Ren.	7-1-2013
291-097-0023	12-28-2012	Suspend	2-1-2013
291-097-0023	6-1-2013	Repeal	7-1-2013
291-097-0025	12-28-2012	Am. & Ren.(T)	2-1-2013
291-097-0025	6-1-2013	Am. & Ren.	7-1-2013
291-097-0030	12-28-2012	Am. & Ren.(T)	2-1-2013
291-097-0030	6-1-2013	Am. & Ren.	7-1-2013
291-097-0031	12-28-2012	Suspend	2-1-2013
291-097-0031	6-1-2013	Repeal	7-1-2013
291-097-0040	12-28-2012	Am. & Ren.(T)	2-1-2013
291-097-0040	6-1-2013	Am. & Ren.	7-1-2013
291-097-0050	12-28-2012	Am. & Ren.(T)	2-1-2013
291-097-0050	6-1-2013	Am. & Ren.	7-1-2013
291-097-0060	12-28-2012	Am. & Ren.(T)	2-1-2013
291-097-0060	6-1-2013	Am. & Ren.	7-1-2013
291-097-0070	12-28-2012	Am. & Ren.(T)	2-1-2013
291-097-0070	6-1-2013	Am. & Ren.	7-1-2013
291-097-0080	12-28-2012	Am. & Ren.(T)	2-1-2013
291-097-0080	6-1-2013	Am. & Ren.	7-1-2013
291-097-0090	12-28-2012	Am. & Ren.(T)	2-1-2013
291-097-0090	6-1-2013	Am. & Ren.	7-1-2013
291-097-0100	12-28-2012	Am. & Ren.(T)	2-1-2013
291-097-0100	6-1-2013	Am. & Ren.	7-1-2013
291-097-0120	12-28-2012	Am. & Ren.(T)	2-1-2013
291-097-0120	6-1-2013	Am. & Ren.	7-1-2013
291-097-0130	12-28-2012	Am. & Ren.(T)	2-1-2013
291-097-0130	6-1-2013	Am. & Ren.	7-1-2013
291-097-0140	12-28-2012	Am. & Ren.(T)	2-1-2013
291-097-0140	6-1-2013	Am. & Ren.	7-1-2013
291-097-0200(T)	6-1-2013	Repeal	7-1-2013
291-097-0210(T)	6-1-2013	Repeal	7-1-2013
291-097-0215(T)	6-1-2013	Repeal	7-1-2013
291-097-0220	12-28-2012	Adopt(T)	2-1-2013
291-097-0220	6-1-2013	Adopt	7-1-2013
291-097-0220(T)	6-1-2013	Repeal	7-1-2013
291-097-0225	12-28-2012	Adopt(T)	2-1-2013
291-097-0225	6-1-2013	Adopt	7-1-2013
291-097-0225(T)	6-1-2013	Repeal	7-1-2013
291-097-0230	12-28-2012	Adopt(T)	2-1-2013
291-097-0230	6-1-2013	Adopt	7-1-2013
291-097-0230(T)	6-1-2013	Repeal	7-1-2013
291-097-0235	12-28-2012	Adopt(T)	2-1-2013
291-097-0235	6-1-2013	Adopt	7-1-2013
291-097-0235(T)	6-1-2013	Repeal	7-1-2013
291-097-0240(T)	6-1-2013	Repeal	7-1-2013
291-097-0245	12-28-2012	Adopt(T)	2-1-2013
291-097-0245	6-1-2013	Adopt	7-1-2013
291-097-0245(T)	6-1-2013	Repeal	7-1-2013
291-097-0250(T)	6-1-2013	Repeal	7-1-2013
291-097-0255(T)	6-1-2013	Repeal	7-1-2013
291-097-0260(T)	6-1-2013	Repeal	7-1-2013
291-097-0265(T)	6-1-2013	Repeal	7-1-2013
291-097-0270(T)	6-1-2013	Repeal	7-1-2013
291-097-0275(T)	6-1-2013	Repeal	7-1-2013
291-097-0280(T)	6-1-2013	Repeal	7-1-2013
291-097-0285(T)	6-1-2013	Repeal	7-1-2013
291-097-0290(T)	6-1-2013	Repeal	7-1-2013
291-097-0295(T)	6-1-2013	Repeal	7-1-2013
291-097-0300(T)	6-1-2013	Repeal	7-1-2013
291-097-0305(T)	6-1-2013	Repeal	7-1-2013
291-104-0111	4-15-2013	Amend	5-1-2013
291-130-0006	2-22-2013	Amend	4-1-2013
291-130-0006(T)	2-22-2013	Repeal	4-1-2013
291-130-0011	2-22-2013	Amend	4-1-2013
291-130-0011(T)	2-22-2013	Repeal	4-1-2013
291-130-0016	2-22-2013	Amend	4-1-2013
291-130-0020	2-22-2013	Amend	4-1-2013
291-130-0020(T)	2-22-2013	Repeal	4-1-2013
291-130-0080	2-22-2013	Amend	4-1-2013
291-130-0080(T)	2-22-2013	Repeal	4-1-2013
291-207-0100	1-1-2013	Adopt	2-1-2013
309-011-0024	12-28-2012	Adopt	2-1-2013

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309-011-0030	12-28-2012	Adopt	2-1-2013
309-011-0032	12-28-2012	Adopt	2-1-2013
309-011-0034	12-28-2012	Adopt	2-1-2013
309-011-0036	12-28-2012	Adopt	2-1-2013
309-011-0120	12-28-2012	Amend	2-1-2013
309-011-0125	12-28-2012	Amend	2-1-2013
309-011-0130	12-28-2012	Amend	2-1-2013
309-011-0135	12-28-2012	Repeal	2-1-2013
309-011-0140	12-28-2012	Renumber	2-1-2013
309-016-0605	6-5-2013	Amend	7-1-2013
309-016-0825	1-7-2013	Adopt(T)	2-1-2013
309-016-0825	6-5-2013	Adopt	7-1-2013
309-016-0825(T)	6-5-2013	Repeal	7-1-2013
309-016-0830	6-5-2013	Adopt	7-1-2013
309-016-0835	6-5-2013	Adopt	7-1-2013
309-016-0837	6-5-2013	Adopt	7-1-2013
309-016-0840	6-5-2013	Adopt	7-1-2013
309-016-0845	6-5-2013	Adopt	7-1-2013
309-016-0850	6-5-2013	Adopt	7-1-2013
309-016-0855	6-5-2013	Adopt	7-1-2013
309-032-1505	2-11-2013	Amend(T)	3-1-2013
309-032-1510	2-11-2013	Amend(T)	3-1-2013
309-032-1525	2-11-2013	Amend(T)	3-1-2013
309-032-1530	2-11-2013	Amend(T)	3-1-2013
309-032-1535	2-11-2013	Amend(T)	3-1-2013
309-032-1540	2-11-2013	Amend(T)	3-1-2013
309-039-0700	6-5-2013	Repeal	7-1-2013
309-039-0710	6-5-2013	Repeal	7-1-2013
309-039-0720	6-5-2013	Repeal	7-1-2013
309-039-0730	6-5-2013	Repeal	7-1-2013
309-039-0740	6-5-2013	Repeal	7-1-2013
309-039-0750	6-5-2013	Repeal	7-1-2013
309-039-0760	6-5-2013	Repeal	7-1-2013
309-039-0770	6-5-2013	Repeal	7-1-2013
309-039-0780	6-5-2013	Repeal	7-1-2013
309-039-0790	6-5-2013	Repeal	7-1-2013
309-090-0005	12-26-2012	Amend	2-1-2013
309-090-0025	12-26-2012	Amend	2-1-2013
309-112-0000	1-23-2013	Amend(T)	3-1-2013
309-112-0005	1-23-2013	Amend(T)	3-1-2013
309-112-0010	1-23-2013	Amend(T)	3-1-2013
309-112-0015	1-23-2013	Amend(T)	3-1-2013
309-112-0017	1-23-2013	Amend(T)	3-1-2013
309-112-0020	1-23-2013	Amend(T)	3-1-2013
309-112-0025	1-23-2013	Amend(T)	3-1-2013
309-112-0030	1-23-2013	Amend(T)	3-1-2013
309-112-0035	1-23-2013	Amend(T)	3-1-2013
325-005-0015	4-25-2013	Amend	6-1-2013
325-005-0015	7-3-2013	Amend	8-1-2013
330-070-0010	1-1-2013	Amend	2-1-2013
330-070-0013	1-1-2013	Amend	2-1-2013
330-070-0014	1-1-2013	Amend	2-1-2013
330-070-0019	1-1-2013	Amend	2-1-2013
330-070-0020	1-1-2013	Amend	2-1-2013
330-070-0021	1-1-2013	Amend	2-1-2013
330-070-0022	1-1-2013	Amend	2-1-2013
330-070-0024	1-1-2013	Amend	2-1-2013
330-070-0025	1-1-2013	Amend	2-1-2013
330-070-0026	1-1-2013	Amend	2-1-2013
330-070-0027	1-1-2013	Amend	2-1-2013
330-070-0029	1-1-2013	Amend	2-1-2013
330-070-0040	1-1-2013	Amend	2-1-2013
330-070-0045	1-1-2013	Amend	2-1-2013
330-070-0048	1-1-2013	Amend	2-1-2013
330-070-0055	1-1-2013	Amend	2-1-2013
330-070-0059	1-1-2013	Amend	2-1-2013
330-070-0060	1-1-2013	Amend	2-1-2013
330-070-0062	1-1-2013	Amend	2-1-2013
330-070-0063	1-1-2013	Amend	2-1-2013
330-070-0064	1-1-2013	Amend	2-1-2013
330-070-0070	1-1-2013	Amend	2-1-2013
330-070-0073	1-1-2013	Amend	2-1-2013
330-070-0089	1-1-2013	Amend	2-1-2013
330-070-0091	1-1-2013	Amend	2-1-2013
330-090-0133	5-13-2013	Amend	6-1-2013
330-090-0140	11-16-2012	Amend(T)	1-1-2013
330-090-0140	5-13-2013	Amend	6-1-2013
330-090-0140(T)	5-13-2013	Repeal	6-1-2013
330-090-0150	5-13-2013	Amend	6-1-2013
330-090-0160	11-16-2012	Amend(T)	1-1-2013
330-090-0160	5-13-2013	Amend	6-1-2013
330-090-0160(T)	5-13-2013	Repeal	6-1-2013
330-110-0005	12-20-2012	Amend	2-1-2013
330-110-0010	12-20-2012	Amend	2-1-2013
330-110-0015	12-20-2012	Amend	2-1-2013
330-110-0016	12-20-2012	Amend	2-1-2013
330-110-0020	12-20-2012	Repeal	2-1-2013
330-110-0025	12-20-2012	Amend	2-1-2013
330-110-0030	12-20-2012	Amend	2-1-2013
330-110-0035	12-20-2012	Amend	2-1-2013
330-110-0036	12-20-2012	Amend	2-1-2013
330-110-0040	12-20-2012	Amend	2-1-2013
330-110-0040	6-17-2013	Amend(T)	8-1-2013
330-110-0042	12-20-2012	Amend	2-1-2013
330-110-0045	12-20-2012	Amend	2-1-2013
330-110-0046	12-20-2012	Adopt	2-1-2013
330-110-0047	12-20-2012	Adopt	2-1-2013
330-110-0048	12-20-2012	Adopt	2-1-2013
330-110-0050	12-20-2012	Repeal	2-1-2013
330-110-0055	12-20-2012	Amend	2-1-2013
330-135-0010	1-1-2013	Amend	2-1-2013
330-135-0015	1-1-2013	Amend	2-1-2013
330-135-0018	1-1-2013	Adopt	2-1-2013
330-135-0020	1-1-2013	Amend	2-1-2013
330-135-0025	1-1-2013	Amend	2-1-2013
330-135-0030	1-1-2013	Amend	2-1-2013
330-135-0035	1-1-2013	Amend	2-1-2013
330-135-0040	1-1-2013	Amend	2-1-2013
330-135-0045	1-1-2013	Amend	2-1-2013
330-135-0047	1-1-2013	Adopt	2-1-2013

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330-135-0050	1-1-2013	Amend	2-1-2013
330-135-0055	1-1-2013	Amend	2-1-2013
331-405-0020	7-1-2013	Amend	8-1-2013
331-405-0030	7-1-2013	Am. & Ren.	8-1-2013
331-405-0045	7-1-2013	Repeal	8-1-2013
331-407-0000	7-1-2013	Am. & Ren.	8-1-2013
331-410-0010	7-1-2013	Repeal	8-1-2013
331-410-0012	7-1-2013	Adopt	8-1-2013
331-410-0015	7-1-2013	Adopt	8-1-2013
331-410-0020	7-1-2013	Amend	8-1-2013
331-410-0025	7-1-2013	Adopt	8-1-2013
331-410-0030	7-1-2013	Amend	8-1-2013
331-410-0035	7-1-2013	Adopt	8-1-2013
331-410-0040	7-1-2013	Repeal	8-1-2013
331-410-0045	7-1-2013	Adopt	8-1-2013
331-410-0050	7-1-2013	Amend	8-1-2013
331-410-0055	7-1-2013	Adopt	8-1-2013
331-410-0060	7-1-2013	Amend	8-1-2013
331-410-0065	7-1-2013	Amend	8-1-2013
331-410-0080	7-1-2013	Amend	8-1-2013
331-410-0090	7-1-2013	Amend	8-1-2013
331-415-0000	7-1-2013	Repeal	8-1-2013
331-415-0010	7-1-2013	Amend	8-1-2013
331-415-0020	7-1-2013	Amend	8-1-2013
331-420-0000	7-1-2013	Amend	8-1-2013
331-420-0010	7-1-2013	Amend	8-1-2013
331-420-0020	7-1-2013	Amend	8-1-2013
331-425-0010	7-1-2013	Repeal	8-1-2013
331-430-0030	7-1-2013	Amend	8-1-2013
331-705-0072	6-1-2013	Repeal	7-1-2013
331-705-0080	4-1-2013	Amend(T)	4-1-2013
331-705-0080	6-1-2013	Amend	7-1-2013
331-710-0040	6-1-2013	Repeal	7-1-2013
331-710-0050	4-1-2013	Amend	4-1-2013
331-710-0080	11-19-2012	Amend(T)	1-1-2013
331-710-0080	4-1-2013	Amend	4-1-2013
331-710-0090	11-19-2012	Amend(T)	1-1-2013
331-710-0090	4-1-2013	Amend	4-1-2013
331-718-0020	11-19-2012	Amend(T)	1-1-2013
331-718-0020	4-1-2013	Amend	4-1-2013
331-900-0000	1-16-2013	Amend	3-1-2013
331-900-0005	1-16-2013	Amend	3-1-2013
331-900-0010	1-16-2013	Amend	3-1-2013
331-900-0020	1-16-2013	Amend(T)	3-1-2013
331-900-0020	3-15-2013	Amend	4-1-2013
331-900-0025	1-16-2013	Amend(T)	3-1-2013
331-900-0025	3-15-2013	Amend	4-1-2013
331-900-0035	1-16-2013	Amend	3-1-2013
331-900-0040	1-16-2013	Amend	3-1-2013
331-900-0050	1-16-2013	Amend(T)	3-1-2013
331-900-0050	3-15-2013	Amend	4-1-2013
331-900-0055	1-16-2013	Amend(T)	3-1-2013
331-900-0055	3-15-2013	Amend	4-1-2013
331-900-0065	1-16-2013	Amend	3-1-2013
331-900-0080	1-16-2013	Amend	3-1-2013
331-900-0085	1-16-2013	Amend	3-1-2013
331-900-0090	1-16-2013	Amend	3-1-2013
331-900-0095	1-16-2013	Amend	3-1-2013
331-900-0097	1-16-2013	Amend	3-1-2013
331-900-0098	1-16-2013	Amend	3-1-2013
331-900-0105	1-16-2013	Amend	3-1-2013
331-900-0115	1-16-2013	Amend	3-1-2013
331-900-0120	1-16-2013	Amend	3-1-2013
331-900-0125	1-16-2013	Amend	3-1-2013
331-900-0130	1-16-2013	Amend	3-1-2013
331-905-0000	1-16-2013	Amend	3-1-2013
331-905-0000	4-1-2013	Amend(T)	5-1-2013
331-905-0000	7-1-2013	Amend	8-1-2013
331-905-0005	1-16-2013	Amend	3-1-2013
331-905-0005	4-1-2013	Amend(T)	5-1-2013
331-905-0005	7-1-2013	Amend	8-1-2013
331-905-0010	1-16-2013	Amend	3-1-2013
331-905-0010	4-1-2013	Amend(T)	5-1-2013
331-905-0010	7-1-2013	Amend	8-1-2013
331-905-0011	1-16-2013	Amend(T)	3-1-2013
331-905-0011	3-15-2013	Amend	4-1-2013
331-905-0012	1-16-2013	Amend	3-1-2013
331-905-0013	1-16-2013	Amend(T)	3-1-2013
331-905-0013	3-15-2013	Amend	4-1-2013
331-905-0014	1-16-2013	Amend	3-1-2013
331-905-0015	1-16-2013	Amend	3-1-2013
331-905-0025	1-16-2013	Amend	3-1-2013
331-905-0035	1-16-2013	Amend	3-1-2013
331-905-0040	1-16-2013	Amend	3-1-2013
331-905-0040	4-1-2013	Amend(T)	5-1-2013
331-905-0040	7-1-2013	Amend	8-1-2013
331-905-0045	1-16-2013	Amend	3-1-2013
331-905-0050	1-16-2013	Amend	3-1-2013
331-905-0050	4-1-2013	Amend(T)	5-1-2013
331-905-0050	7-1-2013	Amend	8-1-2013
331-905-0052	1-16-2013	Amend	3-1-2013
331-905-0055	1-16-2013	Amend	3-1-2013
331-905-0058	1-16-2013	Amend	3-1-2013
331-905-0060	1-16-2013	Amend	3-1-2013
331-905-0070	4-1-2013	Suspend	5-1-2013
331-905-0070	7-1-2013	Repeal	8-1-2013
331-905-0075	1-16-2013	Amend	3-1-2013
331-905-0080	1-16-2013	Amend	3-1-2013
331-905-0080	4-1-2013	Amend(T)	5-1-2013
331-905-0080	7-1-2013	Amend	8-1-2013
331-905-0085	1-16-2013	Amend	3-1-2013
331-905-0090	1-16-2013	Amend	3-1-2013
331-905-0095	1-16-2013	Amend	3-1-2013
331-905-0100	1-16-2013	Amend	3-1-2013
331-905-0105	1-16-2013	Amend	3-1-2013
331-905-0110	1-16-2013	Amend	3-1-2013
331-905-0115	1-16-2013	Amend	3-1-2013
331-905-0120	1-16-2013	Amend	3-1-2013
331-910-0010	1-16-2013	Amend	3-1-2013
331-910-0025	1-16-2013	Amend	3-1-2013
331-910-0035	1-16-2013	Amend	3-1-2013

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331-910-0070	1-16-2013	Amend	3-1-2013
331-910-0080	1-16-2013	Amend	3-1-2013
331-910-0085	1-16-2013	Amend	3-1-2013
331-915-0000	1-16-2013	Amend	3-1-2013
331-915-0015	1-16-2013	Amend	3-1-2013
331-915-0020	1-16-2013	Amend	3-1-2013
331-915-0025	1-16-2013	Amend	3-1-2013
331-915-0035	1-16-2013	Amend	3-1-2013
331-915-0050	1-16-2013	Amend	3-1-2013
331-915-0055	1-16-2013	Amend	3-1-2013
331-915-0060	1-16-2013	Amend	3-1-2013
331-915-0065	1-16-2013	Amend	3-1-2013
331-915-0070	1-16-2013	Amend	3-1-2013
331-915-0075	1-16-2013	Amend	3-1-2013
331-915-0080	1-16-2013	Amend	3-1-2013
331-915-0085	1-16-2013	Amend	3-1-2013
331-920-0000	1-16-2013	Amend	3-1-2013
331-920-0005	1-16-2013	Amend	3-1-2013
331-925-0000	1-16-2013	Amend	3-1-2013
331-925-0005	1-16-2013	Amend	3-1-2013
331-925-0010	1-16-2013	Amend	3-1-2013
331-925-0015	1-16-2013	Amend	3-1-2013
331-925-0020	1-16-2013	Amend	3-1-2013
331-925-0025	1-16-2013	Amend	3-1-2013
331-925-0030	1-16-2013	Amend	3-1-2013
331-925-0035	1-16-2013	Amend	3-1-2013
331-925-0040	1-16-2013	Amend	3-1-2013
331-925-0050	1-16-2013	Amend	3-1-2013
331-940-0000	7-1-2013	Amend(T)	7-1-2013
331-940-0000	7-9-2013	Amend	8-1-2013
331-950-0010	1-16-2013	Amend	3-1-2013
331-950-0020	1-16-2013	Amend	3-1-2013
331-950-0040	1-16-2013	Amend	3-1-2013
332-020-0010	7-12-2013	Amend(T)	8-1-2013
333-002-0300	2-4-2013	Adopt(T)	3-1-2013
333-002-0305	2-4-2013	Adopt(T)	3-1-2013
333-002-0310	2-4-2013	Adopt(T)	3-1-2013
333-002-0315	2-4-2013	Adopt(T)	3-1-2013
333-002-0320	2-4-2013	Adopt(T)	3-1-2013
333-002-0325	2-4-2013	Adopt(T)	3-1-2013
333-002-0327	2-4-2013	Adopt(T)	3-1-2013
333-002-0340	2-4-2013	Adopt(T)	3-1-2013
333-002-0345	2-4-2013	Adopt(T)	3-1-2013
333-002-0350	2-4-2013	Adopt(T)	3-1-2013
333-002-0355	2-4-2013	Adopt(T)	3-1-2013
333-002-0360	2-4-2013	Adopt(T)	3-1-2013
333-002-0370	2-4-2013	Adopt(T)	3-1-2013
333-002-0375	2-4-2013	Adopt(T)	3-1-2013
333-002-0380	2-4-2013	Adopt(T)	3-1-2013
333-004-0000	12-26-2012	Amend	2-1-2013
333-004-0010	12-26-2012	Amend	2-1-2013
333-004-0020	12-26-2012	Amend	2-1-2013
333-004-0030	12-26-2012	Amend	2-1-2013
333-004-0040	12-26-2012	Amend	2-1-2013
333-004-0050	12-26-2012	Amend	2-1-2013
333-004-0060	12-26-2012	Amend	2-1-2013
333-004-0070	12-26-2012	Amend	2-1-2013
333-004-0080	12-26-2012	Amend	2-1-2013
333-004-0100	12-26-2012	Amend	2-1-2013
333-004-0110	12-26-2012	Amend	2-1-2013
333-004-0120	12-26-2012	Amend	2-1-2013
333-004-0130	12-26-2012	Amend	2-1-2013
333-004-0140	12-26-2012	Amend	2-1-2013
333-004-0150	12-26-2012	Amend	2-1-2013
333-004-0160	12-26-2012	Amend	2-1-2013
333-004-0170	12-26-2012	Repeal	2-1-2013
333-004-0180	12-26-2012	Repeal	2-1-2013
333-004-0190	12-26-2012	Repeal	2-1-2013
333-004-0200	12-26-2012	Adopt	2-1-2013
333-004-0210	12-26-2012	Adopt	2-1-2013
333-004-0220	12-26-2012	Adopt	2-1-2013
333-004-0230	12-26-2012	Adopt	2-1-2013
333-008-0090	1-1-2013	Amend	2-1-2013
333-010-0400	2-4-2013	Adopt	3-1-2013
333-010-0405	2-4-2013	Adopt	3-1-2013
333-010-0410	2-4-2013	Adopt	3-1-2013
333-010-0415	2-4-2013	Adopt	3-1-2013
333-010-0420	2-4-2013	Adopt	3-1-2013
333-010-0425	2-4-2013	Adopt	3-1-2013
333-010-0430	2-4-2013	Adopt	3-1-2013
333-010-0435	2-4-2013	Adopt	3-1-2013
333-010-0440	2-4-2013	Adopt	3-1-2013
333-010-0445	2-4-2013	Adopt	3-1-2013
333-010-0450	2-4-2013	Adopt	3-1-2013
333-010-0455	2-4-2013	Adopt	3-1-2013
333-010-0460	2-4-2013	Adopt	3-1-2013
333-010-0465	2-4-2013	Adopt	3-1-2013
333-010-0470	2-4-2013	Adopt	3-1-2013
333-012-0260	2-4-2013	Repeal	3-1-2013
333-012-0262	2-4-2013	Repeal	3-1-2013
333-012-0264	2-4-2013	Repeal	3-1-2013
333-012-0265	2-4-2013	Repeal	3-1-2013
333-012-0266	2-4-2013	Repeal	3-1-2013
333-012-0267	2-4-2013	Repeal	3-1-2013
333-012-0268	2-4-2013	Repeal	3-1-2013
333-012-0269	2-4-2013	Repeal	3-1-2013
333-012-0270	2-4-2013	Repeal	3-1-2013
333-012-0280	2-4-2013	Am. & Ren.	3-1-2013
333-012-0290	2-4-2013	Am. & Ren.	3-1-2013
333-012-0300	2-4-2013	Renumber	3-1-2013
333-012-0310	2-4-2013	Renumber	3-1-2013
333-012-0320	2-4-2013	Renumber	3-1-2013
333-012-0330	2-4-2013	Renumber	3-1-2013
333-012-0340	2-4-2013	Am. & Ren.	3-1-2013
333-012-0350	2-4-2013	Renumber	3-1-2013
333-012-0360	2-4-2013	Renumber	3-1-2013
333-012-0370	2-4-2013	Renumber	3-1-2013
333-012-0380	2-4-2013	Renumber	3-1-2013
333-012-0390	2-4-2013	Renumber	3-1-2013
333-012-0400	2-4-2013	Am. & Ren.	3-1-2013

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333-022-0210	2-4-2013	Adopt	3-1-2013
333-022-0300	2-4-2013	Adopt	3-1-2013
333-022-0305	2-4-2013	Adopt	3-1-2013
333-022-0310	2-4-2013	Adopt	3-1-2013
333-022-0315	2-4-2013	Adopt	3-1-2013
333-030-0015	1-25-2013	Amend	3-1-2013
333-030-0020	1-25-2013	Amend	3-1-2013
333-030-0025	1-25-2013	Amend	3-1-2013
333-030-0030	1-25-2013	Amend	3-1-2013
333-030-0035	1-25-2013	Amend	3-1-2013
333-030-0040	1-25-2013	Amend	3-1-2013
333-030-0045	1-25-2013	Repeal	3-1-2013
333-030-0050	1-25-2013	Amend	3-1-2013
333-030-0055	1-25-2013	Amend	3-1-2013
333-030-0060	1-25-2013	Amend	3-1-2013
333-030-0065	1-25-2013	Amend	3-1-2013
333-030-0070	1-25-2013	Amend	3-1-2013
333-030-0075	1-25-2013	Amend	3-1-2013
333-030-0080	1-25-2013	Amend	3-1-2013
333-030-0085	1-25-2013	Amend	3-1-2013
333-030-0090	1-25-2013	Amend	3-1-2013
333-030-0095	1-25-2013	Amend	3-1-2013
333-030-0100	1-25-2013	Amend	3-1-2013
333-030-0103	1-25-2013	Amend	3-1-2013
333-030-0105	1-25-2013	Amend	3-1-2013
333-030-0110	1-25-2013	Amend	3-1-2013
333-030-0115	1-25-2013	Amend	3-1-2013
333-030-0120	1-25-2013	Amend	3-1-2013
333-030-0125	1-25-2013	Amend	3-1-2013
333-030-0130	1-25-2013	Amend	3-1-2013
333-052-0030	12-20-2012	Amend	2-1-2013
333-052-0040	12-20-2012	Amend	2-1-2013
333-052-0043	12-20-2012	Adopt	2-1-2013
333-052-0044	12-20-2012	Adopt	2-1-2013
333-052-0050	12-20-2012	Amend	2-1-2013
333-052-0060	12-20-2012	Amend	2-1-2013
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333-052-0070	12-20-2012	Amend	2-1-2013
333-052-0080	12-20-2012	Amend	2-1-2013
333-052-0090	12-20-2012	Amend	2-1-2013
333-052-0100	12-20-2012	Amend	2-1-2013
333-052-0120	12-20-2012	Amend	2-1-2013
333-052-0130	12-20-2012	Amend	2-1-2013
333-055-0100	7-1-2013	Adopt(T)	8-1-2013
333-055-0105	7-1-2013	Adopt(T)	8-1-2013
333-055-0110	7-1-2013	Adopt(T)	8-1-2013
333-061-0025	1-25-2013	Amend	3-1-2013
333-061-0030	1-25-2013	Amend	3-1-2013
333-061-0032	1-25-2013	Amend	3-1-2013
333-061-0034	1-25-2013	Amend	3-1-2013
333-061-0036	1-25-2013	Amend	3-1-2013
333-061-0040	1-25-2013	Amend	3-1-2013
333-061-0042	1-25-2013	Amend	3-1-2013
333-061-0043	1-25-2013	Amend	3-1-2013
333-061-0045	1-25-2013	Amend	3-1-2013
333-061-0050	1-25-2013	Amend	3-1-2013
333-061-0058	1-25-2013	Repeal	3-1-2013
333-061-0065	1-25-2013	Amend	3-1-2013
333-061-0070	1-25-2013	Amend	3-1-2013
333-061-0071	1-25-2013	Amend	3-1-2013
333-061-0072	1-25-2013	Amend	3-1-2013
333-061-0073	1-25-2013	Amend	3-1-2013
333-061-0074	1-25-2013	Amend	3-1-2013
333-061-0077	1-25-2013	Amend	3-1-2013
333-061-0087	1-25-2013	Amend	3-1-2013
333-061-0090	1-25-2013	Amend	3-1-2013
333-061-0098	1-25-2013	Amend	3-1-2013
333-061-0220	1-25-2013	Amend	3-1-2013
333-061-0225	1-25-2013	Amend	3-1-2013
333-061-0228	1-25-2013	Amend	3-1-2013
333-061-0235	1-25-2013	Amend	3-1-2013
333-061-0245	1-25-2013	Amend	3-1-2013
333-061-0250	1-25-2013	Amend	3-1-2013
333-061-0335	1-25-2013	Amend	3-1-2013
333-100-0005	1-29-2013	Amend	3-1-2013
333-102-0115	1-29-2013	Amend	3-1-2013
333-102-0203	1-29-2013	Amend	3-1-2013
333-102-0250	1-29-2013	Amend	3-1-2013
333-102-0285	1-29-2013	Amend	3-1-2013
333-102-0340	1-29-2013	Amend	3-1-2013
333-106-0045	1-29-2013	Amend	3-1-2013
333-106-0101	1-29-2013	Amend	3-1-2013
333-106-0305	1-29-2013	Amend	3-1-2013
333-106-0315	1-29-2013	Amend	3-1-2013
333-106-0325	1-29-2013	Amend	3-1-2013
333-106-0370	1-29-2013	Amend	3-1-2013
333-106-0720	1-29-2013	Amend	3-1-2013
333-116-0040	1-29-2013	Amend	3-1-2013
333-116-0050	1-29-2013	Amend	3-1-2013
333-116-0090	1-29-2013	Amend	3-1-2013
333-116-0405	1-29-2013	Repeal	3-1-2013
333-116-0640	1-29-2013	Amend	3-1-2013
333-116-0660	1-29-2013	Amend	3-1-2013
333-116-0670	1-29-2013	Amend	3-1-2013
333-116-0680	1-29-2013	Amend	3-1-2013
333-116-0683	1-29-2013	Amend	3-1-2013
333-116-0687	1-29-2013	Amend	3-1-2013
333-116-0690	1-29-2013	Amend	3-1-2013
333-116-0700	1-29-2013	Amend	3-1-2013
333-116-0715	1-29-2013	Amend	3-1-2013
333-116-0720	1-29-2013	Amend	3-1-2013
333-116-0740	1-29-2013	Amend	3-1-2013
333-116-0880	1-29-2013	Amend	3-1-2013
333-116-0905	1-29-2013	Amend	3-1-2013
333-118-0150	1-29-2013	Amend	3-1-2013
333-119-0040	1-29-2013	Amend	3-1-2013
333-119-0041	1-29-2013	Adopt	3-1-2013
333-119-0080	1-29-2013	Amend	3-1-2013
333-120-0630	1-29-2013	Amend	3-1-2013
333-120-0730	1-29-2013	Amend	3-1-2013

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333-123-0055	1-29-2013	Adopt	3-1-2013
333-123-0060	1-29-2013	Adopt	3-1-2013
333-123-0065	1-29-2013	Adopt	3-1-2013
333-123-0070	1-29-2013	Adopt	3-1-2013
333-123-0075	1-29-2013	Adopt	3-1-2013
333-123-0080	1-29-2013	Adopt	3-1-2013
333-123-0085	1-29-2013	Adopt	3-1-2013
333-123-0090	1-29-2013	Adopt	3-1-2013
333-123-0095	1-29-2013	Adopt	3-1-2013
333-123-0100	1-29-2013	Adopt	3-1-2013
333-123-0105	1-29-2013	Adopt	3-1-2013
333-123-0110	1-29-2013	Adopt	3-1-2013
333-123-0115	1-29-2013	Adopt	3-1-2013
333-200-0010	1-1-2013	Amend	2-1-2013
333-200-0020	1-1-2013	Amend	2-1-2013
333-200-0080	1-1-2013	Amend	2-1-2013
333-200-0090	1-1-2013	Amend	2-1-2013
333-250-0010	1-25-2013	Amend	3-1-2013
333-250-0020	1-25-2013	Amend	3-1-2013
333-250-0030	1-25-2013	Amend	3-1-2013
333-250-0031	1-25-2013	Adopt	3-1-2013
333-250-0040	1-25-2013	Amend	3-1-2013
333-250-0041	1-25-2013	Amend	3-1-2013
333-250-0042	1-25-2013	Amend	3-1-2013
333-250-0043	1-25-2013	Amend	3-1-2013
333-250-0044	1-25-2013	Amend	3-1-2013
333-250-0045	1-25-2013	Amend	3-1-2013
333-250-0047	1-25-2013	Amend	3-1-2013
333-250-0048	1-25-2013	Amend	3-1-2013
333-250-0050	1-25-2013	Amend	3-1-2013
333-250-0060	1-25-2013	Amend	3-1-2013
333-250-0070	1-25-2013	Amend	3-1-2013
333-250-0080	1-25-2013	Amend	3-1-2013
333-250-0100	1-25-2013	Amend	3-1-2013
333-255-0000	1-25-2013	Amend	3-1-2013
333-255-0010	1-25-2013	Amend	3-1-2013
333-255-0020	1-25-2013	Amend	3-1-2013
333-255-0030	1-25-2013	Amend	3-1-2013
333-255-0040	1-25-2013	Amend	3-1-2013
333-255-0050	1-25-2013	Amend	3-1-2013
333-255-0060	1-25-2013	Amend	3-1-2013
333-255-0070	1-25-2013	Amend	3-1-2013
333-255-0071	1-25-2013	Amend	3-1-2013
333-255-0072	1-25-2013	Amend	3-1-2013
333-255-0073	1-25-2013	Amend	3-1-2013
333-255-0079	1-25-2013	Amend	3-1-2013
333-255-0080	1-25-2013	Amend	3-1-2013
333-255-0081	1-25-2013	Amend	3-1-2013
333-255-0082	1-25-2013	Amend	3-1-2013
333-255-0090	1-25-2013	Amend	3-1-2013
333-255-0091	1-25-2013	Amend	3-1-2013
333-255-0092	1-25-2013	Amend	3-1-2013
333-255-0093	1-25-2013	Amend	3-1-2013
333-265-0000	1-25-2013	Amend	3-1-2013
333-265-0010	1-25-2013	Amend	3-1-2013
333-265-0011	1-25-2013	Adopt	3-1-2013
333-265-0014	1-25-2013	Amend	3-1-2013
333-265-0015	1-25-2013	Amend	3-1-2013
333-265-0023	1-25-2013	Amend	3-1-2013
333-265-0024	1-25-2013	Adopt	3-1-2013
333-265-0025	1-25-2013	Amend	3-1-2013
333-265-0050	1-25-2013	Amend	3-1-2013
333-265-0060	1-25-2013	Amend	3-1-2013
333-265-0085	1-25-2013	Amend	3-1-2013
333-265-0105	1-25-2013	Amend	3-1-2013
333-265-0110	1-25-2013	Amend	3-1-2013
333-265-0160	1-25-2013	Amend	3-1-2013
333-265-0190	1-25-2013	Repeal	3-1-2013
333-500-0005	1-1-2013	Amend	2-1-2013
333-500-0010	1-1-2013	Amend	2-1-2013
333-500-0031	1-1-2013	Amend	2-1-2013
333-500-0032	1-1-2013	Amend	2-1-2013
333-500-0038	1-1-2013	Amend	2-1-2013
333-505-0001	1-1-2013	Amend	2-1-2013
333-505-0005	1-1-2013	Amend	2-1-2013
333-505-0007	1-1-2013	Amend	2-1-2013
333-505-0010	1-1-2013	Amend	2-1-2013
333-505-0030	1-1-2013	Amend	2-1-2013
333-505-0033	1-1-2013	Amend	2-1-2013
333-505-0050	1-1-2013	Amend	2-1-2013
333-505-0060	1-1-2013	Amend	2-1-2013
333-505-0080	1-1-2013	Amend	2-1-2013
333-510-0020	1-1-2013	Amend	2-1-2013
333-510-0040	1-1-2013	Amend	2-1-2013
333-520-0035	1-1-2013	Amend	2-1-2013
333-520-0050	1-1-2013	Amend	2-1-2013
333-520-0060	1-1-2013	Amend	2-1-2013
333-520-0070	1-1-2013	Amend	2-1-2013
333-525-0010	1-1-2013	Repeal	2-1-2013
334-001-0012	7-1-2013	Amend	7-1-2013
334-001-0060	1-1-2013	Amend	1-1-2013
334-010-0005	7-1-2013	Amend	7-1-2013
334-010-0015	7-1-2013	Amend	7-1-2013
334-010-0027	1-1-2013	Amend	1-1-2013
334-010-0027	7-1-2013	Amend	7-1-2013
334-010-0029	1-1-2013	Amend	1-1-2013
334-010-0029	7-1-2013	Amend	7-1-2013
334-010-0046	1-1-2013	Amend	1-1-2013
334-040-0010	1-1-2013	Amend	1-1-2013
334-040-0010	7-1-2013	Amend	7-1-2013
335-005-0010	12-14-2012	Amend	1-1-2013
335-005-0020	5-1-2013	Amend	5-1-2013
335-060-0005	12-14-2012	Amend	1-1-2013
335-060-0005	5-1-2013	Amend	5-1-2013
335-060-0005	7-1-2013	Amend(T)	8-1-2013
335-060-0006	12-14-2012	Adopt	1-1-2013
335-060-0006	5-1-2013	Amend	5-1-2013
335-060-0006	5-17-2013	Amend(T)	7-1-2013
335-060-0007	12-14-2012	Adopt	1-1-2013
335-060-0007	5-1-2013	Amend	5-1-2013
335-060-0010	5-1-2013	Amend	5-1-2013

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335-070-0010	5-1-2013	Repeal	5-1-2013
335-070-0020	5-1-2013	Amend	5-1-2013
335-070-0020	5-17-2013	Amend(T)	7-1-2013
335-070-0030	5-1-2013	Repeal	5-1-2013
335-070-0040	5-1-2013	Amend	5-1-2013
335-070-0050	5-1-2013	Amend	5-1-2013
335-070-0050	5-17-2013	Amend(T)	7-1-2013
335-070-0055	5-1-2013	Repeal	5-1-2013
335-070-0060	5-1-2013	Repeal	5-1-2013
335-070-0065	5-1-2013	Repeal	5-1-2013
335-070-0070	5-1-2013	Repeal	5-1-2013
335-070-0075	5-1-2013	Repeal	5-1-2013
335-070-0080	5-1-2013	Amend	5-1-2013
335-070-0080	5-17-2013	Amend(T)	7-1-2013
335-070-0085	5-1-2013	Repeal	5-1-2013
335-080-0005	12-14-2012	Amend	1-1-2013
335-080-0005	5-1-2013	Amend	5-1-2013
335-080-0010	12-14-2012	Amend	1-1-2013
335-080-0010	5-1-2013	Amend	5-1-2013
335-080-0015	12-14-2012	Amend	1-1-2013
335-080-0015	5-1-2013	Amend	5-1-2013
335-080-0025	12-14-2012	Amend	1-1-2013
335-080-0025	5-1-2013	Amend	5-1-2013
335-085-0010	7-1-2013	Adopt(T)	8-1-2013
335-095-0030	12-14-2012	Amend	1-1-2013
335-095-0030	5-1-2013	Amend	5-1-2013
335-095-0040	12-14-2012	Amend	1-1-2013
335-095-0050	12-14-2012	Amend	1-1-2013
337-010-0030	7-1-2013	Amend	5-1-2013
340-041-0007	6-21-2013	Adopt	8-1-2013
340-041-0028	6-21-2013	Adopt	8-1-2013
340-041-0061	6-21-2013	Adopt	8-1-2013
340-048-0055	1-16-2013	Amend	3-1-2013
340-048-0055	3-25-2013	Amend(T)	5-1-2013
340-049-0010	3-1-2013	Amend	3-1-2013
340-049-0015	3-1-2013	Amend	3-1-2013
340-049-0020	3-1-2013	Amend	3-1-2013
340-049-0025	3-1-2013	Amend	3-1-2013
340-049-0030	3-1-2013	Amend	3-1-2013
340-049-0035	3-1-2013	Amend	3-1-2013
340-049-0040	3-1-2013	Amend	3-1-2013
340-049-0055	3-1-2013	Amend	3-1-2013
340-049-0060	3-1-2013	Amend	3-1-2013
340-049-0065	3-1-2013	Amend	3-1-2013
340-049-0085	3-1-2013	Amend	3-1-2013
340-054-0005	12-14-2012	Amend	1-1-2013
340-054-0010	12-14-2012	Amend	1-1-2013
340-054-0011	12-14-2012	Adopt	1-1-2013
340-054-0015	12-14-2012	Amend	1-1-2013
340-054-0020	12-14-2012	Repeal	1-1-2013
340-054-0021	12-14-2012	Repeal	1-1-2013
340-054-0022	12-14-2012	Amend	1-1-2013
340-054-0023	12-14-2012	Repeal	1-1-2013
340-054-0024	12-14-2012	Repeal	1-1-2013
340-054-0025	12-14-2012	Amend	1-1-2013
340-054-0026	12-14-2012	Adopt	1-1-2013
340-054-0027	12-14-2012	Adopt	1-1-2013
340-054-0035	12-14-2012	Repeal	1-1-2013
340-054-0036	12-14-2012	Adopt	1-1-2013
340-054-0055	12-14-2012	Repeal	1-1-2013
340-054-0056	12-14-2012	Adopt	1-1-2013
340-054-0060	12-14-2012	Amend	1-1-2013
340-054-0065	12-14-2012	Amend	1-1-2013
340-054-0085	12-14-2012	Repeal	1-1-2013
340-054-0087	12-14-2012	Repeal	1-1-2013
340-054-0090	12-14-2012	Repeal	1-1-2013
340-054-0093	12-14-2012	Repeal	1-1-2013
340-054-0095	12-14-2012	Repeal	1-1-2013
340-054-0097	12-14-2012	Repeal	1-1-2013
340-054-0098	12-14-2012	Repeal	1-1-2013
340-054-0100	12-14-2012	Amend	1-1-2013
340-054-0102	12-14-2012	Amend	1-1-2013
340-054-0104	12-14-2012	Amend	1-1-2013
340-054-0106	12-14-2012	Amend	1-1-2013
340-054-0108	12-14-2012	Amend	1-1-2013
340-200-0020	3-27-2013	Amend	5-1-2013
340-200-0040	12-10-2012	Amend	1-1-2013
340-200-0040	12-11-2012	Amend	1-1-2013
340-200-0040	3-27-2013	Amend	5-1-2013
340-204-0010	12-11-2012	Amend	1-1-2013
340-210-0100	3-27-2013	Amend	5-1-2013
340-216-0020	3-27-2013	Amend	5-1-2013
340-216-0060	3-27-2013	Amend	5-1-2013
340-216-0062	3-27-2013	Amend	5-1-2013
340-216-0064	3-27-2013	Amend	5-1-2013
340-216-0066	3-27-2013	Amend	5-1-2013
340-216-0068	3-27-2013	Adopt	5-1-2013
340-220-0030	12-11-2012	Amend	1-1-2013
340-220-0040	12-11-2012	Amend	1-1-2013
340-220-0050	12-11-2012	Amend	1-1-2013
340-225-0090	12-11-2012	Amend	1-1-2013
340-228-0602	3-27-2013	Amend	5-1-2013
340-228-0606	3-27-2013	Amend	5-1-2013
340-228-0609	3-27-2013	Amend	5-1-2013
340-228-0611	3-27-2013	Repeal	5-1-2013
340-228-0613	3-27-2013	Repeal	5-1-2013
340-228-0615	3-27-2013	Repeal	5-1-2013
340-228-0617	3-27-2013	Repeal	5-1-2013
340-228-0619	3-27-2013	Repeal	5-1-2013
340-228-0621	3-27-2013	Repeal	5-1-2013
340-228-0623	3-27-2013	Repeal	5-1-2013
340-228-0625	3-27-2013	Repeal	5-1-2013
340-228-0627	3-27-2013	Repeal	5-1-2013
340-228-0629	3-27-2013	Repeal	5-1-2013
340-228-0631	3-27-2013	Repeal	5-1-2013
340-228-0633	3-27-2013	Repeal	5-1-2013
340-228-0635	3-27-2013	Amend	5-1-2013
340-228-0637	3-27-2013	Amend	5-1-2013
340-232-0085	3-27-2013	Amend	5-1-2013
340-238-0040	3-27-2013	Amend	5-1-2013

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340-240-0030	12-11-2012	Amend	1-1-2013
340-240-0500	12-11-2012	Adopt	1-1-2013
340-240-0510	12-11-2012	Adopt	1-1-2013
340-240-0520	12-11-2012	Adopt	1-1-2013
340-240-0530	12-11-2012	Adopt	1-1-2013
340-240-0540	12-11-2012	Adopt	1-1-2013
340-240-0550	12-11-2012	Adopt	1-1-2013
340-240-0560	12-11-2012	Adopt	1-1-2013
340-240-0570	12-11-2012	Adopt	1-1-2013
340-240-0580	12-11-2012	Adopt	1-1-2013
340-240-0610	12-11-2012	Adopt	1-1-2013
340-240-0620	12-11-2012	Adopt	1-1-2013
340-240-0630	12-11-2012	Adopt	1-1-2013
340-244-0030	3-27-2013	Amend	5-1-2013
340-244-0210	3-27-2013	Amend	5-1-2013
340-244-0220	3-27-2013	Amend	5-1-2013
340-244-0230	3-27-2013	Repeal	5-1-2013
340-244-0234	3-27-2013	Amend	5-1-2013
340-244-0238	3-27-2013	Amend	5-1-2013
340-244-0239	3-27-2013	Adopt	5-1-2013
340-244-0240	3-27-2013	Amend	5-1-2013
340-244-0242	3-27-2013	Amend	5-1-2013
340-244-0244	3-27-2013	Amend	5-1-2013
340-244-0246	3-27-2013	Amend	5-1-2013
340-244-0248	3-27-2013	Amend	5-1-2013
340-244-0250	3-27-2013	Amend	5-1-2013
340-253-0000	12-11-2012	Adopt	1-1-2013
340-253-0040	12-11-2012	Adopt	1-1-2013
340-253-0060	12-11-2012	Adopt	1-1-2013
340-253-0100	12-11-2012	Adopt	1-1-2013
340-253-0200	12-11-2012	Adopt	1-1-2013
340-253-0250	12-11-2012	Adopt	1-1-2013
340-253-0310	12-11-2012	Adopt	1-1-2013
340-253-0320	12-11-2012	Adopt	1-1-2013
340-253-0330	12-11-2012	Adopt	1-1-2013
340-253-0340	12-11-2012	Adopt	1-1-2013
340-253-0400	12-11-2012	Adopt	1-1-2013
340-253-0450	12-11-2012	Adopt	1-1-2013
340-253-0500	12-11-2012	Adopt	1-1-2013
340-253-0600	12-11-2012	Adopt	1-1-2013
340-253-0630	12-11-2012	Adopt	1-1-2013
340-253-0650	12-11-2012	Adopt	1-1-2013
340-253-1000	12-11-2012	Adopt	1-1-2013
340-253-1010	12-11-2012	Adopt	1-1-2013
340-253-1020	12-11-2012	Adopt	1-1-2013
340-253-1030	12-11-2012	Adopt	1-1-2013
340-253-3000	12-11-2012	Adopt	1-1-2013
340-253-3010	12-11-2012	Adopt	1-1-2013
340-253-3020	12-11-2012	Adopt	1-1-2013
340-253-3030	12-11-2012	Adopt	1-1-2013
340-253-3040	12-11-2012	Adopt	1-1-2013
340-253-3050	12-11-2012	Adopt	1-1-2013
340-262-1000	12-11-2012	Adopt	1-1-2013
340-264-0040	12-11-2012	Amend	1-1-2013
340-264-0078	12-11-2012	Amend	1-1-2013
340-264-0080	12-11-2012	Amend	1-1-2013
340-264-0100	12-11-2012	Amend	1-1-2013
340-264-0175	12-11-2012	Adopt	1-1-2013
345-029-0060	1-28-2013	Amend	3-1-2013
345-060-0004	1-28-2013	Amend	3-1-2013
345-060-0007	1-28-2013	Amend	3-1-2013
345-060-0025	1-28-2013	Amend	3-1-2013
407-007-0210	2-5-2013	Amend(T)	3-1-2013
407-007-0290	2-5-2013	Amend(T)	3-1-2013
409-021-0130	2-1-2013	Amend	3-1-2013
409-025-0160	2-1-2013	Amend	3-1-2013
409-035-0020	2-1-2013	Amend	3-1-2013
409-055-0030	4-1-2013	Amend	5-1-2013
409-055-0030(T)	4-1-2013	Repeal	5-1-2013
409-060-0100	2-1-2013	Adopt	3-1-2013
409-060-0110	2-1-2013	Adopt	3-1-2013
409-060-0120	2-1-2013	Adopt	3-1-2013
409-060-0130	2-1-2013	Adopt	3-1-2013
409-060-0140	2-1-2013	Adopt	3-1-2013
409-060-0150	2-1-2013	Adopt	3-1-2013
410-050-0861	4-1-2013	Amend(T)	5-1-2013
410-120-0000	7-1-2013	Amend(T)	8-1-2013
410-120-0006	12-1-2012	Amend(T)	1-1-2013
410-120-0006	1-1-2013	Amend	2-1-2013
410-120-0006	1-1-2013	Amend(T)	2-1-2013
410-120-0006	1-8-2013	Amend(T)	2-1-2013
410-120-0006	1-30-2013	Amend(T)	3-1-2013
410-120-0006	2-20-2013	Amend(T)	4-1-2013
410-120-0006	3-1-2013	Amend(T)	4-1-2013
410-120-0006	4-1-2013	Amend	5-1-2013
410-120-0006	4-10-2013	Amend	5-1-2013
410-120-0006	5-29-2013	Amend	7-1-2013
410-120-0006	6-27-2013	Amend	8-1-2013
410-120-0006(T)	12-1-2012	Suspend	1-1-2013
410-120-0006(T)	1-1-2013	Repeal	2-1-2013
410-120-0006(T)	1-1-2013	Suspend	2-1-2013
410-120-0006(T)	1-8-2013	Suspend	2-1-2013
410-120-0006(T)	1-30-2013	Suspend	3-1-2013
410-120-0006(T)	2-20-2013	Suspend	4-1-2013
410-120-0006(T)	3-1-2013	Suspend	4-1-2013
410-120-0006(T)	5-29-2013	Repeal	7-1-2013
410-120-1160	7-1-2013	Amend(T)	8-1-2013
410-120-1200	7-1-2013	Amend(T)	8-1-2013
410-120-1210	1-1-2013	Amend(T)	2-1-2013
410-120-1210	6-27-2013	Amend	8-1-2013
410-120-1210	7-1-2013	Amend(T)	8-1-2013
410-120-1340	3-29-2013	Amend(T)	5-1-2013
410-120-1855	7-1-2013	Amend(T)	8-1-2013
410-121-0030	1-1-2013	Amend	2-1-2013
410-121-0030	2-21-2013	Amend(T)	4-1-2013
410-121-0030	5-1-2013	Amend(T)	6-1-2013
410-121-0030(T)	1-1-2013	Repeal	2-1-2013
410-121-0030(T)	5-1-2013	Suspend	6-1-2013
410-121-0033	1-1-2013	Amend	2-1-2013
410-121-0033(T)	1-1-2013	Repeal	2-1-2013

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410-121-0040	5-1-2013	Amend(T)	6-1-2013
410-121-0040(T)	1-1-2013	Repeal	2-1-2013
410-121-0040(T)	5-1-2013	Suspend	6-1-2013
410-121-0100	1-1-2013	Amend	2-1-2013
410-121-0100(T)	1-1-2013	Repeal	2-1-2013
410-121-0111	1-1-2013	Adopt	2-1-2013
410-121-0111(T)	1-1-2013	Repeal	2-1-2013
410-121-0190	12-28-2012	Amend(T)	2-1-2013
410-121-0190	6-25-2013	Amend	8-1-2013
410-122-0186	12-27-2012	Amend	2-1-2013
410-122-0325	12-27-2012	Amend	2-1-2013
410-123-1060	4-1-2013	Amend	5-1-2013
410-123-1160	4-1-2013	Amend	5-1-2013
410-123-1160	7-1-2013	Amend(T)	8-1-2013
410-123-1200	4-1-2013	Amend	5-1-2013
410-123-1220	4-1-2013	Amend	5-1-2013
410-123-1240	4-1-2013	Amend	5-1-2013
410-123-1260	4-1-2013	Amend	5-1-2013
410-123-1260	7-1-2013	Amend(T)	8-1-2013
410-123-1490	4-1-2013	Amend	5-1-2013
410-123-1490	7-1-2013	Amend(T)	8-1-2013
410-123-1600	7-1-2013	Amend(T)	8-1-2013
410-123-1620	4-1-2013	Amend	5-1-2013
410-127-0020	6-27-2013	Amend	8-1-2013
410-127-0040	6-27-2013	Amend	8-1-2013
410-127-0060	6-27-2013	Amend	8-1-2013
410-127-0080	6-27-2013	Amend	8-1-2013
410-130-0005	3-29-2013	Adopt(T)	5-1-2013
410-130-0180	12-28-2012	Amend(T)	2-1-2013
410-130-0180	6-25-2013	Amend	8-1-2013
410-130-0240	12-28-2012	Amend(T)	2-1-2013
410-130-0240	6-25-2013	Amend	8-1-2013
410-130-0255	3-29-2013	Amend(T)	5-1-2013
410-136-0030	7-1-2013	Repeal	8-1-2013
410-136-0040	7-1-2013	Repeal	8-1-2013
410-136-0045	7-1-2013	Repeal	8-1-2013
410-136-0050	7-1-2013	Repeal	8-1-2013
410-136-0060	7-1-2013	Repeal	8-1-2013
410-136-0070	7-1-2013	Repeal	8-1-2013
410-136-0080	7-1-2013	Repeal	8-1-2013
410-136-0100	7-1-2013	Repeal	8-1-2013
410-136-0120	7-1-2013	Repeal	8-1-2013
410-136-0140	7-1-2013	Repeal	8-1-2013
410-136-0160	7-1-2013	Repeal	8-1-2013
410-136-0180	7-1-2013	Repeal	8-1-2013
410-136-0200	7-1-2013	Repeal	8-1-2013
410-136-0220	7-1-2013	Repeal	8-1-2013
410-136-0240	7-1-2013	Repeal	8-1-2013
410-136-0245	7-1-2013	Repeal	8-1-2013
410-136-0260	7-1-2013	Repeal	8-1-2013
410-136-0280	7-1-2013	Repeal	8-1-2013
410-136-0300	7-1-2013	Repeal	8-1-2013
410-136-0320	7-1-2013	Repeal	8-1-2013
410-136-0340	7-1-2013	Repeal	8-1-2013
410-136-0350	7-1-2013	Repeal	8-1-2013
410-136-0360	7-1-2013	Repeal	8-1-2013
410-136-0420	7-1-2013	Repeal	8-1-2013
410-136-0440	7-1-2013	Repeal	8-1-2013
410-136-0800	7-1-2013	Repeal	8-1-2013
410-136-0820	7-1-2013	Repeal	8-1-2013
410-136-0840	7-1-2013	Repeal	8-1-2013
410-136-0860	7-1-2013	Repeal	8-1-2013
410-136-3000	7-1-2013	Adopt	8-1-2013
410-136-3020	7-1-2013	Adopt	8-1-2013
410-136-3040	7-1-2013	Adopt	8-1-2013
410-136-3060	7-1-2013	Adopt	8-1-2013
410-136-3080	7-1-2013	Adopt	8-1-2013
410-136-3100	7-1-2013	Adopt	8-1-2013
410-136-3120	7-1-2013	Adopt	8-1-2013
410-136-3140	7-1-2013	Adopt	8-1-2013
410-136-3160	7-1-2013	Adopt	8-1-2013
410-136-3180	7-1-2013	Adopt	8-1-2013
410-136-3200	7-1-2013	Adopt	8-1-2013
410-136-3220	7-1-2013	Adopt	8-1-2013
410-136-3240	7-1-2013	Adopt	8-1-2013
410-136-3260	7-1-2013	Adopt	8-1-2013
410-136-3280	7-1-2013	Adopt	8-1-2013
410-136-3300	7-1-2013	Adopt	8-1-2013
410-136-3320	7-1-2013	Adopt	8-1-2013
410-136-3340	7-1-2013	Adopt	8-1-2013
410-136-3360	7-1-2013	Adopt	8-1-2013
410-138-0390	4-26-2013	Amend	6-1-2013
410-141-0262	3-1-2013	Amend(T)	4-1-2013
410-141-0262	4-10-2013	Amend(T)	5-1-2013
410-141-0520	3-21-2013	Amend	5-1-2013
410-141-3060	1-1-2013	Amend(T)	2-1-2013
410-141-3060	2-7-2013	Amend(T)	3-1-2013
410-141-3060	6-27-2013	Amend	8-1-2013
410-141-3060	7-9-2013	Amend(T)	8-1-2013
410-141-3060(T)	2-7-2013	Suspend	3-1-2013
410-141-3080	4-23-2013	Amend	6-1-2013
410-141-3080	6-11-2013	Amend	7-1-2013
410-141-3080	7-9-2013	Amend(T)	8-1-2013
410-141-3160	1-4-2013	Amend(T)	2-1-2013
410-141-3160	6-27-2013	Amend	8-1-2013
410-141-3220	7-9-2013	Amend(T)	8-1-2013
410-141-3260	4-26-2013	Amend	6-1-2013
410-141-3262	3-1-2013	Amend(T)	4-1-2013
410-141-3262	4-10-2013	Amend(T)	5-1-2013
410-141-3420	7-9-2013	Amend(T)	8-1-2013
410-142-0020	5-1-2013	Amend(T)	5-1-2013
410-142-0020	6-27-2013	Amend	8-1-2013
410-142-0290	5-1-2013	Amend(T)	5-1-2013
410-142-0290	6-27-2013	Amend	8-1-2013
410-147-0360	3-1-2013	Amend(T)	4-1-2013
410-147-0400	1-1-2013	Amend(T)	2-1-2013
410-147-0400	3-1-2013	Amend(T)	4-1-2013
410-147-0400	6-27-2013	Amend	8-1-2013
410-147-0400(T)	3-1-2013	Suspend	4-1-2013
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410-165-0060	4-26-2013	Amend(T)	6-1-2013
410-165-0080	4-26-2013	Amend(T)	6-1-2013
410-165-0100	4-26-2013	Amend(T)	6-1-2013
410-165-0120	4-26-2013	Amend(T)	6-1-2013
410-165-0140	4-26-2013	Amend(T)	6-1-2013
411-001-0500	4-2-2013	Adopt	5-1-2013
411-001-0500(T)	4-2-2013	Repeal	5-1-2013
411-001-0510	4-2-2013	Adopt	5-1-2013
411-001-0510	7-1-2013	Amend(T)	8-1-2013
411-001-0520	4-2-2013	Adopt	5-1-2013
411-001-0520	6-1-2013	Amend	7-1-2013
411-015-0005	7-1-2013	Amend(T)	8-1-2013
411-015-0008	7-1-2013	Amend(T)	8-1-2013
411-015-0015	7-1-2013	Amend(T)	8-1-2013
411-015-0100	7-1-2013	Amend(T)	8-1-2013
411-020-0002	11-28-2012	Amend	1-1-2013
411-020-0002(T)	11-28-2012	Repeal	1-1-2013
411-020-0030	11-28-2012	Amend	1-1-2013
411-020-0030(T)	11-28-2012	Repeal	1-1-2013
411-020-0085	11-28-2012	Amend	1-1-2013
411-020-0085(T)	11-28-2012	Repeal	1-1-2013
411-020-0123	11-28-2012	Adopt	1-1-2013
411-020-0123(T)	11-28-2012	Repeal	1-1-2013
411-020-0126	11-28-2012	Adopt	1-1-2013
411-020-0126(T)	11-28-2012	Repeal	1-1-2013
411-028-0000	7-1-2013	Adopt(T)	8-1-2013
411-028-0010	7-1-2013	Adopt(T)	8-1-2013
411-028-0020	7-1-2013	Adopt(T)	8-1-2013
411-028-0030	7-1-2013	Adopt(T)	8-1-2013
411-028-0040	7-1-2013	Adopt(T)	8-1-2013
411-028-0050	7-1-2013	Adopt(T)	8-1-2013
411-030-0002	5-23-2013	Amend(T)	7-1-2013
411-030-0020	5-23-2013	Amend(T)	7-1-2013
411-030-0020	7-1-2013	Amend(T)	8-1-2013
411-030-0020(T)	7-1-2013	Suspend	8-1-2013
411-030-0033	5-23-2013	Amend(T)	7-1-2013
411-030-0040	5-23-2013	Amend(T)	7-1-2013
411-030-0050	5-23-2013	Amend(T)	7-1-2013
411-030-0055	5-23-2013	Amend(T)	7-1-2013
411-030-0070	7-1-2013	Amend(T)	8-1-2013
411-030-0080	3-26-2013	Amend	5-1-2013
411-030-0080	5-23-2013	Amend(T)	7-1-2013
411-030-0080(T)	3-26-2013	Repeal	5-1-2013
411-030-0090	5-23-2013	Amend(T)	7-1-2013
411-030-0100	7-1-2013	Amend(T)	8-1-2013
411-031-0020	3-26-2013	Amend	5-1-2013
411-031-0020	7-1-2013	Amend(T)	8-1-2013
411-031-0020(T)	3-26-2013	Repeal	5-1-2013
411-031-0030	3-26-2013	Amend	5-1-2013
411-031-0040	3-26-2013	Amend	5-1-2013
411-031-0040	7-1-2013	Amend(T)	8-1-2013
411-031-0040(T)	3-26-2013	Repeal	5-1-2013
411-031-0050	3-26-2013	Amend	5-1-2013
411-032-0000	7-1-2013	Amend	7-1-2013
411-032-0001	7-1-2013	Amend	7-1-2013
411-032-0005	7-1-2013	Amend	7-1-2013
411-032-0010	7-1-2013	Amend	7-1-2013
411-032-0013	7-1-2013	Repeal	7-1-2013
411-032-0015	7-1-2013	Amend	7-1-2013
411-032-0020	7-1-2013	Amend	7-1-2013
411-032-0044	7-1-2013	Amend	7-1-2013
411-034-0000	7-1-2013	Amend(T)	8-1-2013
411-034-0010	7-1-2013	Amend(T)	8-1-2013
411-034-0020	7-1-2013	Amend(T)	8-1-2013
411-034-0030	7-1-2013	Amend(T)	8-1-2013
411-034-0035	7-1-2013	Amend(T)	8-1-2013
411-034-0040	7-1-2013	Amend(T)	8-1-2013
411-034-0050	7-1-2013	Amend(T)	8-1-2013
411-034-0055	7-1-2013	Amend(T)	8-1-2013
411-034-0070	7-1-2013	Amend(T)	8-1-2013
411-034-0090	7-1-2013	Amend(T)	8-1-2013
411-040-0000	7-1-2013	Amend(T)	8-1-2013
411-045-0010	7-1-2013	Amend(T)	8-1-2013
411-045-0050	7-1-2013	Amend(T)	8-1-2013
411-048-0000	4-15-2013	Repeal	5-1-2013
411-048-0010	4-15-2013	Repeal	5-1-2013
411-048-0020	4-15-2013	Repeal	5-1-2013
411-048-0030	4-15-2013	Repeal	5-1-2013
411-048-0040	4-15-2013	Repeal	5-1-2013
411-048-0050	4-15-2013	Repeal	5-1-2013
411-048-0060	4-15-2013	Repeal	5-1-2013
411-048-0070	4-15-2013	Repeal	5-1-2013
411-048-0080	4-15-2013	Repeal	5-1-2013
411-048-0100	4-15-2013	Repeal	5-1-2013
411-048-0120	4-15-2013	Repeal	5-1-2013
411-048-0130	4-15-2013	Repeal	5-1-2013
411-048-0150	4-15-2013	Adopt	5-1-2013
411-048-0150	7-1-2013	Amend(T)	8-1-2013
411-048-0160	4-15-2013	Adopt	5-1-2013
411-048-0160	7-1-2013	Amend(T)	8-1-2013
411-048-0170	4-15-2013	Adopt	5-1-2013
411-048-0170	7-1-2013	Amend(T)	8-1-2013
411-048-0180	4-15-2013	Adopt	5-1-2013
411-048-0190	4-15-2013	Adopt	5-1-2013
411-048-0200	4-15-2013	Adopt	5-1-2013
411-048-0210	4-15-2013	Adopt	5-1-2013
411-048-0220	4-15-2013	Adopt	5-1-2013
411-048-0230	4-15-2013	Adopt	5-1-2013
411-048-0240	4-15-2013	Adopt	5-1-2013
411-048-0250	4-15-2013	Adopt	5-1-2013
411-050-0405	5-23-2013	Amend(T)	7-1-2013
411-065-0000	7-1-2013	Amend(T)	8-1-2013
411-070-0005	3-1-2013	Amend	4-1-2013
411-070-0005(T)	3-1-2013	Repeal	4-1-2013
411-070-0033	7-1-2013	Amend(T)	8-1-2013
411-070-0091	3-1-2013	Amend	4-1-2013
411-070-0091(T)	3-1-2013	Repeal	4-1-2013
411-070-0140	5-1-2013	Amend(T)	6-1-2013
411-070-0452	7-1-2013	Amend(T)	8-1-2013
411-070-0470	1-1-2013	Amend(T)	2-1-2013

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411-300-0110	7-1-2013	Amend(T)	8-1-2013
411-300-0120	7-1-2013	Amend(T)	8-1-2013
411-300-0130	7-1-2013	Amend(T)	8-1-2013
411-300-0140	7-1-2013	Amend(T)	8-1-2013
411-300-0150	7-1-2013	Amend(T)	8-1-2013
411-308-0010	7-1-2013	Amend(T)	8-1-2013
411-308-0020	7-1-2013	Amend(T)	8-1-2013
411-308-0030	7-1-2013	Amend(T)	8-1-2013
411-308-0050	7-1-2013	Amend(T)	8-1-2013
411-308-0060	7-1-2013	Amend(T)	8-1-2013
411-308-0070	7-1-2013	Amend(T)	8-1-2013
411-308-0080	7-1-2013	Amend(T)	8-1-2013
411-308-0100	7-1-2013	Amend(T)	8-1-2013
411-308-0120	7-1-2013	Amend(T)	8-1-2013
411-320-0020	7-1-2013	Amend(T)	8-1-2013
411-320-0030	7-1-2013	Amend(T)	8-1-2013
411-320-0040	7-1-2013	Amend(T)	8-1-2013
411-320-0060	7-1-2013	Amend(T)	8-1-2013
411-320-0070	7-1-2013	Amend(T)	8-1-2013
411-320-0090	7-1-2013	Amend(T)	8-1-2013
411-320-0100	7-1-2013	Amend(T)	8-1-2013
411-320-0110	7-1-2013	Amend(T)	8-1-2013
411-320-0120	7-1-2013	Amend(T)	8-1-2013
411-320-0130	7-1-2013	Amend(T)	8-1-2013
411-320-0175	4-2-2013	Amend	5-1-2013
411-325-0020	7-1-2013	Amend(T)	8-1-2013
411-325-0390	7-1-2013	Amend(T)	8-1-2013
411-325-0400	7-1-2013	Amend(T)	8-1-2013
411-325-0440	7-1-2013	Amend(T)	8-1-2013
411-328-0560	7-1-2013	Amend(T)	8-1-2013
411-328-0790	7-1-2013	Amend(T)	8-1-2013
411-328-0800	7-1-2013	Amend(T)	8-1-2013
411-330-0020	1-4-2013	Amend	2-1-2013
411-330-0020	7-1-2013	Amend(T)	8-1-2013
411-330-0020(T)	1-4-2013	Repeal	2-1-2013
411-330-0030	7-1-2013	Amend(T)	8-1-2013
411-330-0040	7-1-2013	Amend(T)	8-1-2013
411-330-0050	7-1-2013	Amend(T)	8-1-2013
411-330-0060	7-1-2013	Amend(T)	8-1-2013
411-330-0065	1-4-2013	Adopt	2-1-2013
411-330-0065(T)	1-4-2013	Repeal	2-1-2013
411-330-0070	7-1-2013	Amend(T)	8-1-2013
411-330-0080	7-1-2013	Amend(T)	8-1-2013
411-330-0090	7-1-2013	Amend(T)	8-1-2013
411-330-0110	7-1-2013	Amend(T)	8-1-2013
411-340-0020	4-1-2013	Amend(T)	5-1-2013
411-340-0020	7-2-2013	Amend(T)	8-1-2013
411-340-0020(T)	7-2-2013	Suspend	8-1-2013
411-340-0100	7-1-2013	Amend(T)	8-1-2013
411-340-0110	7-1-2013	Amend(T)	8-1-2013
411-340-0120	7-1-2013	Amend(T)	8-1-2013
411-340-0125	7-1-2013	Amend(T)	8-1-2013
411-340-0130	7-1-2013	Amend(T)	8-1-2013
411-340-0150	7-1-2013	Amend(T)	8-1-2013
411-345-0020	7-1-2013	Amend(T)	8-1-2013
411-345-0140	7-1-2013	Amend(T)	8-1-2013
411-346-0110	7-1-2013	Amend(T)	8-1-2013
411-346-0180	7-1-2013	Amend(T)	8-1-2013
411-350-0020	7-2-2013	Amend(T)	8-1-2013
411-350-0030	7-2-2013	Amend(T)	8-1-2013
411-350-0040	7-2-2013	Amend(T)	8-1-2013
411-350-0050	7-2-2013	Amend(T)	8-1-2013
411-355-0010	7-2-2013	Amend(T)	8-1-2013
411-355-0020	7-2-2013	Amend(T)	8-1-2013
411-355-0030	7-2-2013	Amend(T)	8-1-2013
411-355-0040	7-2-2013	Amend(T)	8-1-2013
411-360-0090	4-1-2013	Amend(T)	5-1-2013
413-020-0236	1-15-2013	Amend	2-1-2013
413-020-0245	1-15-2013	Amend	2-1-2013
413-030-0000	1-15-2013	Amend	2-1-2013
413-030-0003	1-15-2013	Amend	2-1-2013
413-030-0006	1-15-2013	Amend	2-1-2013
413-030-0009	1-15-2013	Amend	2-1-2013
413-030-0013	1-15-2013	Amend	2-1-2013
413-030-0016	1-15-2013	Amend	2-1-2013
413-030-0019	1-15-2013	Amend	2-1-2013
413-030-0023	1-15-2013	Amend	2-1-2013
413-030-0026	1-15-2013	Amend	2-1-2013
413-030-0030	1-15-2013	Amend	2-1-2013
413-030-0405	1-15-2013	Amend	2-1-2013
413-030-0410	1-15-2013	Amend	2-1-2013
413-030-0445	1-15-2013	Amend	2-1-2013
413-030-0449	1-15-2013	Amend	2-1-2013
413-030-0454	1-15-2013	Amend	2-1-2013
413-030-0456	1-15-2013	Adopt	2-1-2013
413-040-0005	1-15-2013	Amend	2-1-2013
413-040-0006	1-15-2013	Amend	2-1-2013
413-040-0008	1-15-2013	Amend	2-1-2013
413-040-0009	1-15-2013	Amend	2-1-2013
413-040-0010	1-15-2013	Amend	2-1-2013
413-040-0011	1-15-2013	Amend	2-1-2013
413-040-0013	1-15-2013	Amend	2-1-2013
413-040-0016	1-15-2013	Amend	2-1-2013
413-040-0017	1-15-2013	Amend	2-1-2013
413-040-0024	1-15-2013	Amend	2-1-2013
413-040-0032	1-15-2013	Amend	2-1-2013
413-040-0210	1-15-2013	Amend	2-1-2013
413-040-0215	1-15-2013	Amend	2-1-2013
413-040-0240	1-15-2013	Amend	2-1-2013
413-040-0270	1-15-2013	Amend	2-1-2013
413-040-0290	1-15-2013	Amend	2-1-2013
413-040-0300	1-15-2013	Amend	2-1-2013
413-070-0524	1-15-2013	Amend	2-1-2013
413-070-0536	1-15-2013	Amend	2-1-2013
413-070-0551	1-15-2013	Amend	2-1-2013
413-070-0552	1-15-2013	Amend	2-1-2013
413-070-0556	1-15-2013	Amend	2-1-2013
413-070-0565	1-15-2013	Amend	2-1-2013
413-070-0620	1-15-2013	Amend	2-1-2013
413-070-0625	1-15-2013	Amend	2-1-2013

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413-070-0640	1-15-2013	Amend	2-1-2013
413-080-0040	1-15-2013	Amend	2-1-2013
413-080-0050	1-15-2013	Amend	2-1-2013
413-080-0052	1-15-2013	Amend	2-1-2013
413-080-0054	1-15-2013	Adopt	2-1-2013
413-080-0055	1-15-2013	Amend	2-1-2013
413-080-0059	1-15-2013	Amend	2-1-2013
413-080-0063	1-15-2013	Repeal	2-1-2013
413-080-0067	1-15-2013	Amend	2-1-2013
413-120-0860	1-15-2013	Amend	2-1-2013
415-012-0000	1-14-2013	Amend(T)	2-1-2013
415-012-0000	5-3-2013	Amend	6-1-2013
415-012-0010	1-14-2013	Amend(T)	2-1-2013
415-012-0010	5-3-2013	Amend	6-1-2013
415-012-0020	1-14-2013	Amend(T)	2-1-2013
415-012-0020	5-3-2013	Amend	6-1-2013
415-012-0030	1-14-2013	Amend(T)	2-1-2013
415-012-0030	5-3-2013	Amend	6-1-2013
415-012-0032	5-3-2013	Adopt	6-1-2013
415-012-0035	5-3-2013	Adopt	6-1-2013
415-012-0040	5-3-2013	Amend	6-1-2013
415-012-0050	5-3-2013	Amend	6-1-2013
415-012-0055	5-3-2013	Adopt	6-1-2013
415-012-0060	5-3-2013	Amend	6-1-2013
415-012-0065	5-3-2013	Adopt	6-1-2013
415-012-0067	5-3-2013	Adopt	6-1-2013
415-012-0070	5-3-2013	Amend	6-1-2013
415-012-0080	5-3-2013	Amend	6-1-2013
415-012-0090	5-3-2013	Amend	6-1-2013
415-020-0005	6-7-2013	Amend	7-1-2013
415-020-0015	6-7-2013	Amend	7-1-2013
415-020-0017	6-7-2013	Adopt	7-1-2013
415-020-0053	1-14-2013	Amend(T)	2-1-2013
415-020-0053	6-7-2013	Amend	7-1-2013
415-020-0060	6-7-2013	Amend	7-1-2013
415-020-0075	6-7-2013	Amend	7-1-2013
415-020-0085	6-7-2013	Amend	7-1-2013
415-050-0000	2-4-2013	Amend(T)	3-1-2013
415-050-0005	2-4-2013	Amend(T)	3-1-2013
415-050-0015	2-4-2013	Amend(T)	3-1-2013
415-050-0025	2-4-2013	Amend(T)	3-1-2013
415-050-0035	2-4-2013	Amend(T)	3-1-2013
415-050-0040	2-4-2013	Amend(T)	3-1-2013
415-050-0045	2-4-2013	Amend(T)	3-1-2013
415-050-0050	2-4-2013	Amend(T)	3-1-2013
415-050-0055	2-4-2013	Amend(T)	3-1-2013
415-050-0060	2-4-2013	Amend(T)	3-1-2013
415-050-0065	2-4-2013	Amend(T)	3-1-2013
415-050-0070	2-4-2013	Amend(T)	3-1-2013
415-050-0075	2-4-2013	Amend(T)	3-1-2013
415-050-0090	2-4-2013	Amend(T)	3-1-2013
416-465-0000	2-25-2013	Repeal	4-1-2013
416-465-0010	2-25-2013	Repeal	4-1-2013
416-465-0020	2-25-2013	Repeal	4-1-2013
416-465-0030	2-25-2013	Repeal	4-1-2013
416-465-0040	2-25-2013	Repeal	4-1-2013
436-001-0003	12-28-2012	Amend	1-1-2013
436-001-0004	12-28-2012	Amend	1-1-2013
436-001-0005	12-28-2012	Amend	1-1-2013
436-001-0009	12-28-2012	Amend	1-1-2013
436-001-0019	12-28-2012	Amend	1-1-2013
436-001-0023	12-28-2012	Amend	1-1-2013
436-001-0170	12-28-2012	Amend	1-1-2013
436-001-0225	12-28-2012	Amend	1-1-2013
436-001-0246	12-28-2012	Amend	1-1-2013
436-001-0300	12-28-2012	Repeal	1-1-2013
436-001-0410	12-28-2012	Amend	1-1-2013
436-001-0420	12-28-2012	Amend	1-1-2013
436-001-0430	12-28-2012	Amend	1-1-2013
436-009-0004	4-1-2013	Amend	4-1-2013
436-009-0010	4-1-2013	Amend	4-1-2013
436-009-0020	4-1-2013	Amend	4-1-2013
436-009-0025	4-1-2013	Amend	4-1-2013
436-009-0030	4-1-2013	Amend	4-1-2013
436-009-0050	4-1-2013	Amend	4-1-2013
436-009-0070	4-1-2013	Amend	4-1-2013
436-009-0110	4-1-2013	Amend	4-1-2013
436-009-0135	4-1-2013	Amend	4-1-2013
436-009-0175	4-1-2013	Amend	4-1-2013
436-009-0177	4-1-2013	Amend	4-1-2013
436-009-0180	4-1-2013	Amend	4-1-2013
436-009-0207	4-1-2013	Amend	4-1-2013
436-009-0260	4-1-2013	Amend	4-1-2013
436-009-0290	4-1-2013	Amend	4-1-2013
436-010-0210	4-1-2013	Amend	4-1-2013
436-010-0230	4-1-2013	Amend	4-1-2013
436-010-0265	4-1-2013	Amend	4-1-2013
436-010-0330	4-1-2013	Amend	4-1-2013
436-015-0008	4-1-2013	Amend	4-1-2013
436-015-0080	4-1-2013	Amend	4-1-2013
436-015-0110	4-1-2013	Amend	4-1-2013
436-035-0002	1-1-2013	Amend	1-1-2013
436-035-0003	1-1-2013	Amend	1-1-2013
436-035-0005	1-1-2013	Amend	1-1-2013
436-035-0007	1-1-2013	Amend	1-1-2013
436-035-0008	1-1-2013	Amend	1-1-2013
436-035-0009	1-1-2013	Amend	1-1-2013
436-035-0011	1-1-2013	Amend	1-1-2013
436-035-0012	1-1-2013	Amend	1-1-2013
436-035-0017	1-1-2013	Amend	1-1-2013
436-035-0018	1-1-2013	Amend	1-1-2013
436-035-0030	1-1-2013	Amend	1-1-2013
436-035-0040	1-1-2013	Amend	1-1-2013
436-035-0110	1-1-2013	Amend	1-1-2013
436-035-0230	1-1-2013	Amend	1-1-2013
436-035-0235	1-1-2013	Amend	1-1-2013
436-035-0255	1-1-2013	Amend	1-1-2013
436-035-0260	1-1-2013	Amend	1-1-2013
436-035-0265	1-1-2013	Amend	1-1-2013
436-035-0340	1-1-2013	Amend	1-1-2013
436-035-0350	1-1-2013	Amend	1-1-2013

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436-035-0385	1-1-2013	Amend	1-1-2013
436-035-0390	1-1-2013	Amend	1-1-2013
436-035-0395	1-1-2013	Amend	1-1-2013
436-035-0400	1-1-2013	Amend	1-1-2013
436-035-0410	1-1-2013	Amend	1-1-2013
436-035-0420	1-1-2013	Amend	1-1-2013
436-035-0430	1-1-2013	Amend	1-1-2013
436-035-0440	1-1-2013	Amend	1-1-2013
436-035-0450	1-1-2013	Amend	1-1-2013
436-035-0500	1-1-2013	Amend	1-1-2013
436-050-0003	1-23-2013	Amend(T)	3-1-2013
436-050-0003	7-22-2013	Amend	8-1-2013
436-050-0175	1-1-2013	Amend	1-1-2013
436-050-0300	1-23-2013	Amend(T)	3-1-2013
436-050-0300	7-22-2013	Amend	8-1-2013
436-070-0002	4-1-2013	Amend	1-1-2013
436-070-0003	4-1-2013	Amend	1-1-2013
436-070-0010	4-1-2013	Amend	1-1-2013
436-105-0003	7-1-2013	Amend	5-1-2013
436-105-0520	7-1-2013	Amend	5-1-2013
436-110-0150	6-7-2013	Adopt	7-1-2013
437-002-0005	12-14-2012	Amend	1-1-2013
437-002-0020	4-1-2013	Amend	3-1-2013
437-002-0023	4-1-2013	Adopt	3-1-2013
437-002-0120	12-14-2012	Amend	1-1-2013
437-002-0134	4-1-2013	Amend	3-1-2013
437-002-0240	12-14-2012	Amend	1-1-2013
437-003-0001	12-14-2012	Amend	1-1-2013
437-003-0001	2-14-2013	Amend	3-1-2013
437-003-0001	4-1-2013	Amend	3-1-2013
437-003-0128	4-1-2013	Repeal	3-1-2013
437-003-0134	4-1-2013	Adopt	3-1-2013
437-005-0001	12-14-2012	Amend	1-1-2013
437-005-0002	12-14-2012	Amend	1-1-2013
437-005-0003	12-14-2012	Amend	1-1-2013
438-005-0015	4-1-2013	Amend	3-1-2013
438-009-0005	4-1-2013	Amend	3-1-2013
438-009-0020	4-1-2013	Amend	3-1-2013
438-011-0010	4-1-2013	Amend	3-1-2013
438-011-0045	4-1-2013	Amend	3-1-2013
438-012-0001	4-1-2013	Amend	3-1-2013
438-012-0020	4-1-2013	Amend	3-1-2013
438-012-0031	4-1-2013	Amend	3-1-2013
438-012-0035	4-1-2013	Amend	3-1-2013
438-012-0036	4-1-2013	Amend	3-1-2013
438-012-0050	4-1-2013	Amend	3-1-2013
438-012-0060	4-1-2013	Amend	3-1-2013
438-012-0062	4-1-2013	Amend	3-1-2013
438-016-0005	4-1-2013	Amend	3-1-2013
438-019-0010	4-1-2013	Amend	3-1-2013
438-020-0010	4-1-2013	Amend	3-1-2013
438-022-0005	4-1-2013	Amend	3-1-2013
441-505-3090	1-23-2013	Adopt	3-1-2013
441-505-3090(T)	1-23-2013	Repeal	3-1-2013
441-710-0270	2-1-2013	Amend(T)	2-1-2013
442-005-0000	1-1-2013	Amend	2-1-2013
442-005-0010	1-1-2013	Amend	2-1-2013
442-005-0020	1-1-2013	Amend	2-1-2013
442-005-0030	1-1-2013	Amend	2-1-2013
442-005-0040	1-1-2013	Amend	2-1-2013
442-005-0050	1-1-2013	Amend	2-1-2013
442-005-0070	1-1-2013	Amend	2-1-2013
442-005-0080	1-1-2013	Amend	2-1-2013
442-005-0090	1-1-2013	Amend	2-1-2013
442-005-0100	1-1-2013	Amend	2-1-2013
442-005-0110	1-1-2013	Amend	2-1-2013
442-005-0130	1-1-2013	Amend	2-1-2013
442-005-0140	1-1-2013	Amend	2-1-2013
442-005-0150	1-1-2013	Amend	2-1-2013
442-005-0160	1-1-2013	Amend	2-1-2013
442-005-0170	1-1-2013	Amend	2-1-2013
442-005-0180	1-1-2013	Amend	2-1-2013
442-005-0190	1-1-2013	Amend	2-1-2013
442-005-0200	1-1-2013	Amend	2-1-2013
442-005-0210	1-1-2013	Amend	2-1-2013
442-005-0220	1-1-2013	Amend	2-1-2013
442-005-0230	1-1-2013	Amend	2-1-2013
442-005-0235	1-1-2013	Adopt	2-1-2013
442-005-0240	1-1-2013	Amend	2-1-2013
442-005-0260	1-1-2013	Amend	2-1-2013
442-005-0270	1-1-2013	Amend	2-1-2013
442-005-0280	1-1-2013	Amend	2-1-2013
442-005-0290	1-1-2013	Amend	2-1-2013
442-005-0300	1-1-2013	Amend	2-1-2013
442-005-0310	1-1-2013	Amend	2-1-2013
442-005-0320	1-1-2013	Amend	2-1-2013
442-005-0330	1-1-2013	Amend	2-1-2013
442-005-0340	1-1-2013	Amend	2-1-2013
442-005-0350	1-1-2013	Repeal	2-1-2013
442-010-0010	1-1-2013	Amend	2-1-2013
442-010-0020	1-1-2013	Amend	2-1-2013
442-010-0030	1-1-2013	Amend	2-1-2013
442-010-0040	1-1-2013	Amend	2-1-2013
442-010-0050	1-1-2013	Amend	2-1-2013
442-010-0055	1-1-2013	Amend	2-1-2013
442-010-0060	1-1-2013	Amend	2-1-2013
442-010-0070	1-1-2013	Amend	2-1-2013
442-010-0075	1-1-2013	Amend	2-1-2013
442-010-0080	1-1-2013	Amend	2-1-2013
442-010-0085	1-1-2013	Amend	2-1-2013
442-010-0090	1-1-2013	Amend	2-1-2013
442-010-0100	1-1-2013	Amend	2-1-2013
442-010-0110	1-1-2013	Repeal	2-1-2013
442-010-0120	1-1-2013	Amend	2-1-2013
442-010-0140	1-1-2013	Amend	2-1-2013
442-010-0150	1-1-2013	Amend	2-1-2013
442-010-0160	1-1-2013	Amend	2-1-2013
442-010-0170	1-1-2013	Amend	2-1-2013
442-010-0180	1-1-2013	Amend	2-1-2013
442-010-0190	1-1-2013	Amend	2-1-2013

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442-010-0220	1-1-2013	Amend	2-1-2013
442-010-0230	1-1-2013	Amend	2-1-2013
442-010-0240	1-1-2013	Amend	2-1-2013
442-010-0260	1-1-2013	Amend	2-1-2013
442-010-0270	1-1-2013	Amend	2-1-2013
442-010-0280	1-1-2013	Repeal	2-1-2013
459-005-0040	1-25-2013	Amend	3-1-2013
459-005-0400	12-5-2012	Adopt	1-1-2013
459-005-0525	3-29-2013	Amend	5-1-2013
459-005-0545	3-29-2013	Amend	5-1-2013
459-009-0200	1-25-2013	Amend	3-1-2013
459-017-0060	3-29-2013	Amend	5-1-2013
459-035-0001	12-5-2012	Amend	1-1-2013
459-035-0200	12-5-2012	Repeal	1-1-2013
459-035-0220	12-5-2012	Repeal	1-1-2013
459-075-0200	3-29-2013	Amend	5-1-2013
459-080-0500	3-29-2013	Amend	5-1-2013
461-001-0015	4-1-2013	Amend	5-1-2013
461-001-0030	7-1-2013	Amend(T)	8-1-2013
461-025-0300	4-1-2013	Amend	5-1-2013
461-025-0300(T)	4-1-2013	Repeal	5-1-2013
461-025-0301	4-1-2013	Adopt	5-1-2013
461-025-0301(T)	4-1-2013	Repeal	5-1-2013
461-025-0310	7-1-2013	Amend(T)	8-1-2013
461-025-0315	7-1-2013	Amend(T)	8-1-2013
461-110-0210	7-1-2013	Amend(T)	8-1-2013
461-110-0430	4-10-2013	Amend(T)	5-1-2013
461-115-0016	1-1-2013	Amend	2-1-2013
461-115-0016(T)	1-1-2013	Repeal	2-1-2013
461-115-0430	1-1-2013	Amend	2-1-2013
461-115-0430	7-1-2013	Amend	8-1-2013
461-120-0210	5-29-2013	Amend(T)	7-1-2013
461-120-0340	12-29-2012	Amend	2-1-2013
461-120-0340	4-1-2013	Amend	5-1-2013
461-125-0050	4-1-2013	Amend	5-1-2013
461-125-0830	1-1-2013	Amend(T)	2-1-2013
461-125-0830	4-1-2013	Amend	5-1-2013
461-125-0830(T)	4-1-2013	Repeal	5-1-2013
461-130-0310	1-1-2013	Amend(T)	2-1-2013
461-130-0310	4-1-2013	Amend	5-1-2013
461-130-0310	7-1-2013	Amend	8-1-2013
461-130-0310(T)	4-1-2013	Repeal	5-1-2013
461-130-0330	1-1-2013	Amend	2-1-2013
461-130-0335	1-1-2013	Amend	2-1-2013
461-135-0070	7-1-2013	Amend	8-1-2013
461-135-0089	1-1-2013	Amend	2-1-2013
461-135-0400	1-1-2013	Amend(T)	2-1-2013
461-135-0400	7-1-2013	Amend	8-1-2013
461-135-0407	1-1-2013	Adopt	2-1-2013
461-135-0407	5-15-2013	Amend(T)	6-1-2013
461-135-0407(T)	1-1-2013	Repeal	2-1-2013
461-135-0570	5-1-2013	Amend(T)	6-1-2013
461-135-0726	7-1-2013	Amend(T)	8-1-2013
461-135-0750	7-1-2013	Amend(T)	8-1-2013
461-135-0780	1-1-2013	Amend(T)	2-1-2013
461-135-0780	4-1-2013	Amend	5-1-2013
461-135-0780(T)	4-1-2013	Repeal	5-1-2013
461-135-0832	7-1-2013	Amend(T)	8-1-2013
461-135-0835	7-1-2013	Amend(T)	8-1-2013
461-135-0900	7-1-2013	Amend	8-1-2013
461-135-1100	7-1-2013	Amend(T)	8-1-2013
461-135-1101	7-1-2013	Amend(T)	8-1-2013
461-135-1102	12-1-2012	Amend(T)	1-1-2013
461-135-1102	4-1-2013	Amend	5-1-2013
461-135-1102(T)	4-1-2013	Repeal	5-1-2013
461-140-0296	7-1-2013	Amend(T)	8-1-2013
461-145-0080	12-29-2012	Amend	2-1-2013
461-145-0220	1-1-2013	Amend(T)	2-1-2013
461-145-0220	4-1-2013	Amend	5-1-2013
461-145-0220(T)	4-1-2013	Repeal	5-1-2013
461-145-0250	7-1-2013	Amend	8-1-2013
461-145-0260	1-1-2013	Amend	2-1-2013
461-145-0260	1-1-2013	Amend(T)	2-1-2013
461-145-0260	4-1-2013	Amend	5-1-2013
461-145-0260(T)	1-1-2013	Repeal	2-1-2013
461-145-0260(T)	4-1-2013	Repeal	5-1-2013
461-145-0540	7-1-2013	Amend(T)	8-1-2013
461-145-0580	1-1-2013	Amend	2-1-2013
461-145-0580	7-1-2013	Amend(T)	8-1-2013
461-145-0580(T)	1-1-2013	Repeal	2-1-2013
461-150-0060	7-1-2013	Amend	8-1-2013
461-155-0020	7-1-2013	Amend(T)	8-1-2013
461-155-0150	1-1-2013	Amend(T)	2-1-2013
461-155-0150	7-1-2013	Amend	8-1-2013
461-155-0180	1-30-2013	Amend	3-1-2013
461-155-0180	2-1-2013	Amend(T)	3-1-2013
461-155-0180	7-1-2013	Amend	8-1-2013
461-155-0180(T)	7-1-2013	Repeal	8-1-2013
461-155-0235	1-30-2013	Amend	3-1-2013
461-155-0250	1-1-2013	Amend(T)	2-1-2013
461-155-0250	4-1-2013	Amend	5-1-2013
461-155-0250(T)	4-1-2013	Repeal	5-1-2013
461-155-0270	1-1-2013	Amend(T)	2-1-2013
461-155-0270	1-8-2013	Amend(T)	2-1-2013
461-155-0270	4-1-2013	Amend	5-1-2013
461-155-0270	7-1-2013	Amend(T)	8-1-2013
461-155-0270(T)	1-8-2013	Suspend	2-1-2013
461-155-0270(T)	4-1-2013	Repeal	5-1-2013
461-155-0290	3-1-2013	Amend	4-1-2013
461-155-0291	3-1-2013	Amend	4-1-2013
461-155-0295	3-1-2013	Amend	4-1-2013
461-155-0300	1-1-2013	Amend(T)	2-1-2013
461-155-0300	4-1-2013	Amend	5-1-2013
461-155-0300(T)	4-1-2013	Repeal	5-1-2013
461-155-0530	7-1-2013	Amend(T)	8-1-2013
461-155-0575	4-1-2013	Amend	5-1-2013
461-155-0575	7-1-2013	Amend(T)	8-1-2013
461-155-0575(T)	4-1-2013	Repeal	5-1-2013
461-155-0580	7-1-2013	Amend(T)	8-1-2013
461-155-0630	7-1-2013	Amend(T)	8-1-2013

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461-155-0660	7-1-2013	Amend(T)	8-1-2013
461-155-0710	7-1-2013	Amend	8-1-2013
461-160-0010	4-10-2013	Amend(T)	5-1-2013
461-160-0015	1-1-2013	Amend	2-1-2013
461-160-0015	1-1-2013	Amend(T)	2-1-2013
461-160-0015	4-1-2013	Amend	5-1-2013
461-160-0015(T)	4-1-2013	Repeal	5-1-2013
461-160-0030	4-1-2013	Amend	5-1-2013
461-160-0040	7-1-2013	Amend	8-1-2013
461-160-0055	1-1-2013	Amend	2-1-2013
461-160-0055	4-1-2013	Amend	5-1-2013
461-160-0055	7-1-2013	Amend(T)	8-1-2013
461-160-0055(T)	1-1-2013	Repeal	2-1-2013
461-160-0193	4-1-2013	Amend	5-1-2013
461-160-0410	4-1-2013	Amend	5-1-2013
461-160-0415	4-1-2013	Amend	5-1-2013
461-160-0420	4-1-2013	Amend	5-1-2013
461-160-0430	4-1-2013	Amend	5-1-2013
461-160-0540	7-1-2013	Amend(T)	8-1-2013
461-160-0550	7-1-2013	Amend(T)	8-1-2013
461-160-0551	7-1-2013	Amend(T)	8-1-2013
461-160-0580	1-1-2013	Amend	2-1-2013
461-160-0610	7-1-2013	Amend(T)	8-1-2013
461-160-0620	1-1-2013	Amend	2-1-2013
461-160-0620	7-1-2013	Amend(T)	8-1-2013
461-165-0010	2-6-2013	Amend	3-1-2013
461-165-0060	1-1-2013	Amend	2-1-2013
461-165-0100	7-1-2013	Amend(T)	8-1-2013
461-165-0160	4-1-2013	Amend	5-1-2013
461-165-0180	4-1-2013	Amend	5-1-2013
461-165-0190	4-1-2013	Repeal	5-1-2013
461-175-0222	7-1-2013	Amend	8-1-2013
461-175-0230	7-1-2013	Amend(T)	8-1-2013
461-180-0044	7-1-2013	Amend(T)	8-1-2013
461-180-0070	4-1-2013	Amend	5-1-2013
461-180-0100	1-1-2013	Amend	2-1-2013
461-185-0050	7-1-2013	Amend(T)	8-1-2013
461-190-0211	1-1-2013	Amend(T)	2-1-2013
461-190-0211	1-23-2013	Amend(T)	3-1-2013
461-190-0211	4-1-2013	Amend	5-1-2013
461-190-0211	7-1-2013	Amend(T)	8-1-2013
461-190-0211(T)	1-1-2013	Suspend	2-1-2013
461-190-0211(T)	1-23-2013	Suspend	3-1-2013
461-190-0211(T)	4-1-2013	Repeal	5-1-2013
461-193-0320	7-1-2013	Amend	8-1-2013
461-195-0501	3-25-2013	Amend(T)	5-1-2013
461-195-0521	7-1-2013	Amend	8-1-2013
461-195-0521	7-1-2013	Amend(T)	8-1-2013
461-195-0541	3-25-2013	Amend(T)	5-1-2013
461-195-0541	7-1-2013	Amend	8-1-2013
461-195-0541	7-1-2013	Amend(T)	8-1-2013
461-195-0541(T)	7-1-2013	Repeal	8-1-2013
461-195-0601	3-25-2013	Amend(T)	5-1-2013
461-195-0621	3-25-2013	Amend(T)	5-1-2013
462-130-0010	12-31-2012	Amend	2-1-2013
571-004-0020	3-4-2013	Amend	4-1-2013
571-004-0025	3-4-2013	Amend	4-1-2013
571-004-0030	3-4-2013	Amend	4-1-2013
571-004-0037	3-4-2013	Adopt	4-1-2013
571-004-0050	3-4-2013	Amend	4-1-2013
571-004-0055	3-4-2013	Amend	4-1-2013
571-060-0005	3-6-2013	Amend	4-1-2013
571-060-0005	6-27-2013	Amend	8-1-2013
573-040-0005	5-7-2013	Amend	6-1-2013
573-050-0015	6-20-2013	Amend	8-1-2013
573-050-0016	6-20-2013	Amend	8-1-2013
573-050-0025	6-20-2013	Amend	8-1-2013
573-050-0030	6-20-2013	Amend	8-1-2013
573-050-0040	6-20-2013	Amend	8-1-2013
573-076-0040	6-20-2013	Amend	8-1-2013
573-076-0050	6-20-2013	Amend	8-1-2013
573-076-0060	6-20-2013	Amend	8-1-2013
573-076-0070	6-20-2013	Amend	8-1-2013
573-076-0080	6-20-2013	Amend	8-1-2013
573-076-0090	6-20-2013	Amend	8-1-2013
573-076-0100	6-20-2013	Amend	8-1-2013
573-076-0110	6-20-2013	Amend	8-1-2013
573-076-0120	6-20-2013	Amend	8-1-2013
573-076-0130	6-20-2013	Amend	8-1-2013
574-050-0005	1-28-2013	Amend	3-1-2013
576-005-0032	7-1-2013	Amend	7-1-2013
576-005-0035	3-1-2013	Repeal	4-1-2013
576-005-0040	3-1-2013	Repeal	4-1-2013
576-010-0000	1-1-2013	Amend	2-1-2013
576-010-0000	7-1-2013	Amend	7-1-2013
576-026-0005	1-1-2013	Repeal	2-1-2013
576-026-0010	1-1-2013	Repeal	2-1-2013
576-050-0015	1-1-2013	Amend	2-1-2013
576-055-0000	1-16-2013	Adopt	3-1-2013
576-055-0010	1-16-2013	Adopt	3-1-2013
576-055-0020	1-16-2013	Adopt	3-1-2013
576-055-0030	1-16-2013	Adopt	3-1-2013
576-055-0040	1-16-2013	Adopt	3-1-2013
576-055-0050	1-16-2013	Adopt	3-1-2013
576-055-0060	1-16-2013	Adopt	3-1-2013
576-055-0070	1-16-2013	Adopt	3-1-2013
576-055-0080	1-16-2013	Adopt	3-1-2013
576-055-0090	1-16-2013	Adopt	3-1-2013
576-055-0100	1-16-2013	Adopt	3-1-2013
576-055-0110	1-16-2013	Adopt	3-1-2013
576-055-0120	1-16-2013	Adopt	3-1-2013
576-055-0130	1-16-2013	Adopt	3-1-2013
576-055-0140	1-16-2013	Adopt	3-1-2013
576-055-0150	1-16-2013	Adopt	3-1-2013
576-055-0160	1-16-2013	Adopt	3-1-2013
576-056-0000	1-1-2013	Adopt	2-1-2013
576-056-0010	1-1-2013	Adopt	2-1-2013
576-056-0020	1-1-2013	Adopt	2-1-2013
576-056-0030	1-1-2013	Adopt	2-1-2013
576-056-0040	1-1-2013	Adopt	2-1-2013
576-056-0050	1-1-2013	Adopt	2-1-2013

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576-056-0080	1-1-2013	Adopt	2-1-2013
576-056-0090	1-1-2013	Adopt	2-1-2013
576-056-0100	1-1-2013	Adopt	2-1-2013
576-056-0110	1-1-2013	Adopt	2-1-2013
576-056-0120	1-1-2013	Adopt	2-1-2013
576-056-0130	1-1-2013	Adopt	2-1-2013
577-042-0010	3-20-2013	Amend(T)	5-1-2013
577-060-0020	5-30-2013	Amend	7-1-2013
578-041-0030	9-16-2013	Amend	7-1-2013
578-072-0030	9-16-2013	Amend	7-1-2013
579-020-0006	5-28-2013	Amend	7-1-2013
579-070-0005	12-20-2012	Amend	2-1-2013
579-070-0005	2-22-2013	Amend	4-1-2013
579-070-0010	2-22-2013	Amend	4-1-2013
579-070-0015	2-22-2013	Amend	4-1-2013
579-070-0030	2-22-2013	Amend	4-1-2013
579-070-0035	2-22-2013	Amend	4-1-2013
579-070-0041	2-22-2013	Amend	4-1-2013
579-070-0042	2-22-2013	Amend	4-1-2013
579-070-0043	2-22-2013	Amend	4-1-2013
579-070-0045	2-22-2013	Amend	4-1-2013
580-060-0000	4-10-2013	Amend(T)	5-1-2013
580-060-0010	4-10-2013	Amend(T)	5-1-2013
580-060-0015	4-10-2013	Amend(T)	5-1-2013
580-060-0020	4-10-2013	Amend(T)	5-1-2013
580-060-0025	4-10-2013	Amend(T)	5-1-2013
580-060-0035	4-10-2013	Amend(T)	5-1-2013
580-060-0040	4-10-2013	Amend(T)	5-1-2013
580-060-0045	4-10-2013	Amend(T)	5-1-2013
580-060-0050	4-10-2013	Amend(T)	5-1-2013
580-060-0055	4-10-2013	Amend(T)	5-1-2013
580-060-0060	4-10-2013	Suspend	5-1-2013
580-061-0000	4-10-2013	Amend(T)	5-1-2013
580-061-0005	4-10-2013	Amend(T)	5-1-2013
580-061-0010	4-10-2013	Amend(T)	5-1-2013
580-061-0015	4-10-2013	Amend(T)	5-1-2013
580-061-0020	4-10-2013	Amend(T)	5-1-2013
580-061-0025	4-10-2013	Amend(T)	5-1-2013
580-061-0030	4-10-2013	Amend(T)	5-1-2013
580-061-0035	4-10-2013	Amend(T)	5-1-2013
580-061-0040	4-10-2013	Amend(T)	5-1-2013
580-061-0045	4-10-2013	Amend(T)	5-1-2013
580-061-0050	4-10-2013	Amend(T)	5-1-2013
580-061-0055	4-10-2013	Amend(T)	5-1-2013
580-061-0060	4-10-2013	Amend(T)	5-1-2013
580-061-0065	4-10-2013	Amend(T)	5-1-2013
580-061-0070	4-10-2013	Amend(T)	5-1-2013
580-061-0075	4-10-2013	Amend(T)	5-1-2013
580-061-0080	4-10-2013	Amend(T)	5-1-2013
580-061-0085	4-10-2013	Amend(T)	5-1-2013
580-061-0090	4-10-2013	Amend(T)	5-1-2013
580-061-0095	4-10-2013	Amend(T)	5-1-2013
580-061-0100	4-10-2013	Amend(T)	5-1-2013
580-061-0105	4-10-2013	Amend(T)	5-1-2013
580-061-0110	4-10-2013	Amend(T)	5-1-2013
580-061-0115	4-10-2013	Amend(T)	5-1-2013
580-061-0120	4-10-2013	Amend(T)	5-1-2013
580-061-0125	4-10-2013	Amend(T)	5-1-2013
580-061-0130	4-10-2013	Amend(T)	5-1-2013
580-061-0135	4-10-2013	Amend(T)	5-1-2013
580-061-0140	4-10-2013	Amend(T)	5-1-2013
580-061-0145	4-10-2013	Amend(T)	5-1-2013
580-061-0150	4-10-2013	Amend(T)	5-1-2013
580-061-0155	4-10-2013	Amend(T)	5-1-2013
580-061-0160	4-10-2013	Amend(T)	5-1-2013
580-062-0010	4-10-2013	Amend(T)	5-1-2013
580-062-0015	4-10-2013	Amend(T)	5-1-2013
580-062-0020	4-10-2013	Amend(T)	5-1-2013
581-001-0016	1-15-2013	Adopt	2-1-2013
581-002-0090	1-15-2013	Adopt	2-1-2013
581-015-2030	4-9-2013	Amend(T)	5-1-2013
581-015-2030	7-11-2013	Amend	8-1-2013
581-015-2090	4-25-2013	Amend(T)	6-1-2013
581-015-2090	5-30-2013	Amend	7-1-2013
581-015-2110	1-17-2013	Amend	3-1-2013
581-015-2310	4-25-2013	Amend(T)	6-1-2013
581-015-2310	5-30-2013	Amend	7-1-2013
581-015-2530	4-25-2013	Amend(T)	6-1-2013
581-015-2530	5-30-2013	Amend	7-1-2013
581-015-2735	4-25-2013	Amend(T)	6-1-2013
581-015-2735	5-30-2013	Amend	7-1-2013
581-015-2745	4-25-2013	Amend(T)	6-1-2013
581-015-2745	5-30-2013	Amend	7-1-2013
581-015-2885	4-25-2013	Amend(T)	6-1-2013
581-015-2885	5-30-2013	Amend	7-1-2013
581-021-0500	1-17-2013	Amend	3-1-2013
581-021-0500(T)	1-17-2013	Repeal	3-1-2013
581-022-1060	7-11-2013	Amend	8-1-2013
581-022-1065	1-15-2013	Repeal	2-1-2013
581-022-1440	4-10-2013	Amend	5-1-2013
581-022-1670	2-20-2013	Amend	4-1-2013
581-022-2130	4-5-2013	Adopt	5-1-2013
581-045-0003	1-15-2013	Amend	2-1-2013
581-045-0586	1-17-2013	Amend	3-1-2013
581-045-0586(T)	1-17-2013	Repeal	3-1-2013
584-005-0005	2-14-2013	Amend	3-1-2013
584-017-0005	4-30-2013	Repeal	6-1-2013
584-017-0010	4-30-2013	Repeal	6-1-2013
584-017-0020	4-30-2013	Repeal	6-1-2013
584-017-0025	4-30-2013	Repeal	6-1-2013
584-017-0030	4-30-2013	Repeal	6-1-2013
584-017-0035	4-30-2013	Repeal	6-1-2013
584-017-0040	4-30-2013	Repeal	6-1-2013
584-017-0042	4-30-2013	Repeal	6-1-2013
584-017-0045	4-30-2013	Repeal	6-1-2013
584-017-0050	4-30-2013	Repeal	6-1-2013
584-017-0055	4-30-2013	Repeal	6-1-2013
584-017-0057	4-30-2013	Repeal	6-1-2013
584-017-0060	4-30-2013	Repeal	6-1-2013
584-017-0070	4-30-2013	Repeal	6-1-2013

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584-017-0080	4-30-2013	Repeal	6-1-2013
584-017-0085	4-30-2013	Repeal	6-1-2013
584-017-0090	4-30-2013	Repeal	6-1-2013
584-017-0100	4-30-2013	Repeal	6-1-2013
584-017-0115	4-30-2013	Repeal	6-1-2013
584-017-0120	4-30-2013	Repeal	6-1-2013
584-017-0130	4-30-2013	Repeal	6-1-2013
584-017-0140	4-30-2013	Repeal	6-1-2013
584-017-0150	4-30-2013	Repeal	6-1-2013
584-017-0160	4-30-2013	Repeal	6-1-2013
584-017-0170	4-30-2013	Repeal	6-1-2013
584-017-0175	4-30-2013	Repeal	6-1-2013
584-017-0180	4-30-2013	Repeal	6-1-2013
584-017-0182	4-30-2013	Repeal	6-1-2013
584-017-0185	4-30-2013	Repeal	6-1-2013
584-017-0190	4-30-2013	Repeal	6-1-2013
584-017-0200	4-30-2013	Repeal	6-1-2013
584-017-0201	4-30-2013	Repeal	6-1-2013
584-017-0210	4-30-2013	Repeal	6-1-2013
584-017-0220	4-30-2013	Repeal	6-1-2013
584-017-0230	4-30-2013	Repeal	6-1-2013
584-017-0240	4-30-2013	Repeal	6-1-2013
584-017-0251	4-30-2013	Repeal	6-1-2013
584-017-0261	4-30-2013	Repeal	6-1-2013
584-017-0270	4-30-2013	Repeal	6-1-2013
584-017-0280	4-30-2013	Repeal	6-1-2013
584-017-0282	4-30-2013	Repeal	6-1-2013
584-017-0290	4-30-2013	Repeal	6-1-2013
584-017-0300	4-30-2013	Repeal	6-1-2013
584-017-0310	4-30-2013	Repeal	6-1-2013
584-017-0320	4-30-2013	Repeal	6-1-2013
584-017-0330	4-30-2013	Repeal	6-1-2013
584-017-0340	4-30-2013	Repeal	6-1-2013
584-017-0351	4-30-2013	Repeal	6-1-2013
584-017-0355	4-30-2013	Repeal	6-1-2013
584-017-0360	4-30-2013	Repeal	6-1-2013
584-017-0370	4-30-2013	Repeal	6-1-2013
584-017-0380	4-30-2013	Repeal	6-1-2013
584-017-0390	4-30-2013	Repeal	6-1-2013
584-017-0400	4-30-2013	Repeal	6-1-2013
584-017-0410	4-30-2013	Repeal	6-1-2013
584-017-0420	4-30-2013	Repeal	6-1-2013
584-017-0430	4-30-2013	Repeal	6-1-2013
584-017-0441	4-30-2013	Repeal	6-1-2013
584-017-0451	4-30-2013	Repeal	6-1-2013
584-017-0455	4-30-2013	Repeal	6-1-2013
584-017-0460	4-30-2013	Repeal	6-1-2013
584-017-0462	4-30-2013	Repeal	6-1-2013
584-017-0465	4-30-2013	Repeal	6-1-2013
584-017-0470	4-30-2013	Repeal	6-1-2013
584-017-0480	4-30-2013	Repeal	6-1-2013
584-017-0500	4-30-2013	Repeal	6-1-2013
584-017-0510	4-30-2013	Repeal	6-1-2013
584-017-0520	4-30-2013	Repeal	6-1-2013
584-017-0530	4-30-2013	Repeal	6-1-2013
584-017-0541	4-30-2013	Repeal	6-1-2013
584-017-0551	4-30-2013	Repeal	6-1-2013
584-017-0555	4-30-2013	Repeal	6-1-2013
584-017-0560	4-30-2013	Repeal	6-1-2013
584-017-0570	4-30-2013	Repeal	6-1-2013
584-017-0580	4-30-2013	Repeal	6-1-2013
584-017-1028	4-30-2013	Amend	6-1-2013
584-018-0205	2-14-2013	Amend	3-1-2013
584-018-0220	11-19-2012	Adopt	1-1-2013
584-018-0305	2-14-2013	Amend	3-1-2013
584-036-0082	11-19-2012	Repeal	1-1-2013
584-052-0030	11-19-2012	Repeal	1-1-2013
584-052-0031	11-19-2012	Repeal	1-1-2013
584-052-0032	11-19-2012	Repeal	1-1-2013
584-052-0033	11-19-2012	Repeal	1-1-2013
584-066-0015	2-14-2013	Adopt	3-1-2013
584-070-0411	2-14-2013	Amend	3-1-2013
584-080-0031	11-19-2012	Amend	1-1-2013
584-090-0001	4-30-2013	Repeal	6-1-2013
584-090-0005	4-30-2013	Repeal	6-1-2013
584-090-0010	4-30-2013	Repeal	6-1-2013
584-090-0020	4-30-2013	Repeal	6-1-2013
584-090-0030	4-30-2013	Repeal	6-1-2013
584-090-0040	4-30-2013	Repeal	6-1-2013
584-090-0060	4-30-2013	Repeal	6-1-2013
584-090-0115	11-19-2012	Amend	1-1-2013
584-100-0016	2-14-2013	Amend	3-1-2013
584-100-0038	11-19-2012	Amend	1-1-2013
584-100-0038	2-14-2013	Amend	3-1-2013
584-100-0091	11-19-2012	Amend	1-1-2013
584-100-0096	11-19-2012	Amend	1-1-2013
584-100-0101	2-14-2013	Amend	3-1-2013
584-100-0106	2-14-2013	Amend	3-1-2013
585-001-0007	12-17-2012	Adopt	2-1-2013
585-001-0009	12-17-2012	Adopt	2-1-2013
589-002-0100	12-26-2012	Amend	2-1-2013
589-002-0100	6-11-2013	Amend	7-1-2013
589-002-0110	12-26-2012	Adopt	2-1-2013
589-002-0110	6-11-2013	Adopt	7-1-2013
589-002-0120	12-26-2012	Adopt	2-1-2013
589-002-0120	6-11-2013	Adopt	7-1-2013
589-002-0130	12-26-2012	Adopt	2-1-2013
589-002-0130	6-11-2013	Adopt	7-1-2013
589-007-0200	6-25-2013	Amend	8-1-2013
589-007-0500	5-31-2013	Amend(T)	7-1-2013
589-007-0600	5-31-2013	Amend	7-1-2013
589-007-0700	12-26-2012	Amend	2-1-2013
603-013-0905	2-7-2013	Adopt	3-1-2013
603-013-0910	2-7-2013	Adopt	3-1-2013
603-013-0920	2-7-2013	Adopt	3-1-2013
603-013-0932	2-7-2013	Adopt	3-1-2013
603-017-0900	2-7-2013	Adopt	3-1-2013
603-017-0910	2-7-2013	Adopt	3-1-2013
603-017-0920	2-7-2013	Adopt	3-1-2013
603-017-0930	2-7-2013	Adopt	3-1-2013
603-021-0900	2-7-2013	Adopt	3-1-2013

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603-021-0910	2-7-2013	Adopt	3-1-2013
603-021-0920	2-7-2013	Adopt	3-1-2013
603-021-0930	2-7-2013	Adopt	3-1-2013
603-022-0900	2-7-2013	Adopt	3-1-2013
603-022-0910	2-7-2013	Adopt	3-1-2013
603-022-0920	2-7-2013	Adopt	3-1-2013
603-022-0930	2-7-2013	Adopt	3-1-2013
603-024-0017	4-26-2013	Amend	6-1-2013
603-024-0019	4-26-2013	Amend	6-1-2013
603-024-0041	4-26-2013	Amend	6-1-2013
603-024-0211	4-26-2013	Amend	6-1-2013
603-024-0589	4-26-2013	Amend	6-1-2013
603-024-0592	4-26-2013	Amend	6-1-2013
603-024-0605	4-26-2013	Amend	6-1-2013
603-024-0613	4-26-2013	Amend	6-1-2013
603-024-0640	4-26-2013	Amend	6-1-2013
603-024-0900	2-7-2013	Adopt	3-1-2013
603-024-0910	2-7-2013	Adopt	3-1-2013
603-024-0920	2-7-2013	Adopt	3-1-2013
603-024-0930	2-7-2013	Adopt	3-1-2013
603-025-0030	1-1-2013	Amend	2-1-2013
603-025-0900	2-7-2013	Adopt	3-1-2013
603-025-0910	2-7-2013	Adopt	3-1-2013
603-025-0920	2-7-2013	Adopt	3-1-2013
603-025-0930	2-7-2013	Adopt	3-1-2013
603-028-0900	2-7-2013	Adopt	3-1-2013
603-028-0910	2-7-2013	Adopt	3-1-2013
603-028-0920	2-7-2013	Adopt	3-1-2013
603-028-0930	2-7-2013	Adopt	3-1-2013
603-047-0010	12-21-2012	Adopt	2-1-2013
603-047-0100	12-21-2012	Adopt	2-1-2013
603-047-0200	12-21-2012	Adopt	2-1-2013
603-047-0300	12-21-2012	Adopt	2-1-2013
603-047-0400	12-21-2012	Adopt	2-1-2013
603-047-0500	12-21-2012	Adopt	2-1-2013
603-051-0855	3-1-2013	Amend	4-1-2013
603-051-0856	3-1-2013	Amend	4-1-2013
603-051-0857	3-1-2013	Amend	4-1-2013
603-051-0858	3-1-2013	Amend	4-1-2013
603-051-0859	3-1-2013	Amend	4-1-2013
603-052-0075	3-1-2013	Amend	4-1-2013
603-052-0114	3-1-2013	Amend	4-1-2013
603-052-0116	3-1-2013	Amend	4-1-2013
603-052-0127	3-1-2013	Amend	4-1-2013
603-052-0129	3-1-2013	Amend	4-1-2013
603-052-0347	4-26-2013	Amend	6-1-2013
603-052-0850	2-6-2013	Repeal	3-1-2013
603-052-0852	2-6-2013	Repeal	3-1-2013
603-052-0860	2-6-2013	Amend	3-1-2013
603-052-0861	2-6-2013	Adopt	3-1-2013
603-052-0862	2-6-2013	Adopt	3-1-2013
603-052-0870	2-6-2013	Amend	3-1-2013
603-052-0880	2-6-2013	Amend	3-1-2013
603-052-0882	2-6-2013	Adopt	3-1-2013
603-052-0884	2-6-2013	Adopt	3-1-2013
603-052-0886	2-6-2013	Adopt	3-1-2013
603-052-0888	2-6-2013	Adopt	3-1-2013
603-052-0901	2-6-2013	Adopt	3-1-2013
603-052-0921	2-6-2013	Adopt	3-1-2013
603-052-1080	12-3-2012	Adopt	1-1-2013
603-052-1090	12-3-2012	Adopt	1-1-2013
603-052-1200	3-1-2013	Amend	4-1-2013
603-052-1206	12-12-2012	Adopt	1-1-2013
603-052-1209	12-12-2012	Adopt	1-1-2013
603-052-1211	12-12-2012	Adopt	1-1-2013
603-052-1230	3-1-2013	Amend	4-1-2013
603-052-1320	3-1-2013	Amend	4-1-2013
603-057-0386	6-27-2013	Adopt(T)	8-1-2013
603-100-0900	2-7-2013	Adopt	3-1-2013
603-100-0910	2-7-2013	Adopt	3-1-2013
603-100-0920	2-7-2013	Adopt	3-1-2013
603-100-0930	2-7-2013	Adopt	3-1-2013
629-035-0055	7-1-2013	Amend	7-1-2013
629-600-0050	9-1-2013	Adopt	8-1-2013
629-600-0100	9-1-2013	Amend	8-1-2013
629-605-0150	9-1-2013	Amend	8-1-2013
629-605-0160	9-1-2013	Amend	8-1-2013
629-605-0170	9-1-2013	Amend	8-1-2013
629-605-0173	9-1-2013	Amend	8-1-2013
629-605-0180	9-1-2013	Amend	8-1-2013
629-610-0000	9-1-2013	Amend	8-1-2013
629-610-0020	9-1-2013	Amend	8-1-2013
629-610-0070	9-1-2013	Amend	8-1-2013
629-610-0090	9-1-2013	Amend	8-1-2013
629-615-0100	9-1-2013	Amend	8-1-2013
629-615-0300	9-1-2013	Amend	8-1-2013
629-620-0000	9-1-2013	Amend	8-1-2013
629-623-0100	9-1-2013	Amend	8-1-2013
629-623-0200	9-1-2013	Amend	8-1-2013
629-623-0400	9-1-2013	Amend	8-1-2013
629-625-0000	9-1-2013	Amend	8-1-2013
629-625-0500	9-1-2013	Amend	8-1-2013
629-625-0600	9-1-2013	Amend	8-1-2013
629-625-0650	9-1-2013	Amend	8-1-2013
629-630-0800	9-1-2013	Amend	8-1-2013
629-635-0100	9-1-2013	Amend	8-1-2013
629-635-0130	9-1-2013	Repeal	8-1-2013
629-635-0200	9-1-2013	Amend	8-1-2013
629-640-0000	9-1-2013	Amend	8-1-2013
629-640-0100	9-1-2013	Amend	8-1-2013
629-640-0105	9-1-2013	Amend	8-1-2013
629-640-0200	9-1-2013	Amend	8-1-2013
629-645-0000	9-1-2013	Amend	8-1-2013
629-645-0030	9-1-2013	Amend	8-1-2013
629-645-0040	9-1-2013	Amend	8-1-2013
629-645-0050	9-1-2013	Amend	8-1-2013
629-650-0000	9-1-2013	Amend	8-1-2013
629-650-0005	9-1-2013	Adopt	8-1-2013
629-660-0050	9-1-2013	Amend	8-1-2013
629-665-0230	9-1-2013	Amend	8-1-2013
629-670-0214	9-1-2013	Amend	8-1-2013
629-680-0020	9-1-2013	Amend	8-1-2013

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632-010-0006	3-21-2013	Repeal	5-1-2013
632-010-0008	3-21-2013	Amend	5-1-2013
632-010-0010	3-21-2013	Amend	5-1-2013
632-010-0011	3-21-2013	Amend	5-1-2013
632-010-0012	3-21-2013	Amend	5-1-2013
632-010-0014	3-21-2013	Amend	5-1-2013
632-010-0015	3-21-2013	Amend	5-1-2013
632-010-0016	3-21-2013	Amend	5-1-2013
632-010-0017	3-21-2013	Amend	5-1-2013
632-010-0018	3-21-2013	Amend	5-1-2013
632-010-0020	3-21-2013	Amend	5-1-2013
632-010-0128	3-21-2013	Amend	5-1-2013
632-010-0130	3-21-2013	Amend	5-1-2013
632-010-0132	3-21-2013	Amend	5-1-2013
632-010-0134	3-21-2013	Amend	5-1-2013
632-010-0136	3-21-2013	Amend	5-1-2013
632-010-0138	3-21-2013	Amend	5-1-2013
632-010-0140	3-21-2013	Amend	5-1-2013
632-010-0142	3-21-2013	Amend	5-1-2013
632-010-0144	3-21-2013	Amend	5-1-2013
632-010-0146	3-21-2013	Amend	5-1-2013
632-010-0148	3-21-2013	Amend	5-1-2013
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632-010-0152	3-21-2013	Amend	5-1-2013
632-010-0154	3-21-2013	Amend	5-1-2013
632-010-0156	3-21-2013	Amend	5-1-2013
632-010-0157	3-21-2013	Amend	5-1-2013
632-010-0159	3-21-2013	Amend	5-1-2013
632-010-0161	3-21-2013	Amend	5-1-2013
632-010-0162	3-21-2013	Amend	5-1-2013
632-010-0163	3-21-2013	Amend	5-1-2013
632-010-0164	3-21-2013	Amend	5-1-2013
632-010-0165	3-21-2013	Amend	5-1-2013
632-010-0166	3-21-2013	Amend	5-1-2013
632-010-0167	3-21-2013	Amend	5-1-2013
632-010-0168	3-21-2013	Amend	5-1-2013
632-010-0169	3-21-2013	Repeal	5-1-2013
632-010-0170	3-21-2013	Amend	5-1-2013
632-010-0172	3-21-2013	Amend	5-1-2013
632-010-0174	3-21-2013	Amend	5-1-2013
632-010-0176	3-21-2013	Amend	5-1-2013
632-010-0178	3-21-2013	Amend	5-1-2013
632-010-0182	3-21-2013	Amend	5-1-2013
632-010-0184	3-21-2013	Amend	5-1-2013
632-010-0186	3-21-2013	Amend	5-1-2013
632-010-0188	3-21-2013	Amend	5-1-2013
632-010-0190	3-21-2013	Amend	5-1-2013
632-010-0192	3-21-2013	Amend	5-1-2013
632-010-0194	3-21-2013	Amend	5-1-2013
632-010-0196	3-21-2013	Amend	5-1-2013
632-010-0198	3-21-2013	Amend	5-1-2013
632-010-0205	3-21-2013	Amend	5-1-2013
632-010-0210	3-21-2013	Amend	5-1-2013
632-010-0220	3-21-2013	Amend	5-1-2013
632-010-0225	3-21-2013	Amend	5-1-2013
632-010-0230	3-21-2013	Amend	5-1-2013
632-010-0235	3-21-2013	Amend	5-1-2013
632-015-0005	3-21-2013	Amend	5-1-2013
632-015-0010	3-21-2013	Amend	5-1-2013
632-015-0015	3-21-2013	Amend	5-1-2013
632-015-0020	3-21-2013	Amend	5-1-2013
632-015-0025	3-21-2013	Amend	5-1-2013
632-015-0030	3-21-2013	Amend	5-1-2013
632-015-0035	3-21-2013	Amend	5-1-2013
632-015-0040	3-21-2013	Amend	5-1-2013
632-015-0045	3-21-2013	Amend	5-1-2013
632-015-0050	3-21-2013	Amend	5-1-2013
632-015-0055	3-21-2013	Amend	5-1-2013
632-015-0060	3-21-2013	Amend	5-1-2013
632-020-0005	3-21-2013	Amend	5-1-2013
632-020-0010	3-21-2013	Amend	5-1-2013
632-020-0015	3-21-2013	Amend	5-1-2013
632-020-0025	3-21-2013	Amend	5-1-2013
632-020-0028	3-21-2013	Adopt	5-1-2013
632-020-0030	3-21-2013	Amend	5-1-2013
632-020-0031	3-21-2013	Amend	5-1-2013
632-020-0032	3-21-2013	Adopt	5-1-2013
632-020-0035	3-21-2013	Amend	5-1-2013
632-020-0040	3-21-2013	Amend	5-1-2013
632-020-0045	3-21-2013	Repeal	5-1-2013
632-020-0055	3-21-2013	Repeal	5-1-2013
632-020-0060	3-21-2013	Amend	5-1-2013
632-020-0065	3-21-2013	Amend	5-1-2013
632-020-0070	3-21-2013	Amend	5-1-2013
632-020-0090	3-21-2013	Amend	5-1-2013
632-020-0095	3-21-2013	Amend	5-1-2013
632-020-0100	3-21-2013	Amend	5-1-2013
632-020-0105	3-21-2013	Amend	5-1-2013
632-020-0110	3-21-2013	Amend	5-1-2013
632-020-0115	3-21-2013	Amend	5-1-2013
632-020-0117	3-21-2013	Amend	5-1-2013
632-020-0125	3-21-2013	Amend	5-1-2013
632-020-0130	3-21-2013	Amend	5-1-2013
632-020-0135	3-21-2013	Amend	5-1-2013
632-020-0138	3-21-2013	Amend	5-1-2013
632-020-0140	3-21-2013	Amend	5-1-2013
632-020-0145	3-21-2013	Amend	5-1-2013
632-020-0150	3-21-2013	Amend	5-1-2013
632-020-0154	3-21-2013	Amend	5-1-2013
632-020-0155	3-21-2013	Amend	5-1-2013
632-020-0156	3-21-2013	Amend	5-1-2013
632-020-0157	3-21-2013	Amend	5-1-2013
632-020-0159	3-21-2013	Amend	5-1-2013
632-020-0160	3-21-2013	Repeal	5-1-2013
632-020-0170	3-21-2013	Amend	5-1-2013
632-020-0175	3-21-2013	Amend	5-1-2013
632-020-0180	3-21-2013	Amend	5-1-2013
635-003-0003	5-1-2013	Amend(T)	6-1-2013
635-003-0003	5-14-2013	Amend	6-1-2013
635-003-0003(T)	5-14-2013	Repeal	6-1-2013

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635-004-0275	1-3-2013	Amend	2-1-2013
635-004-0310	1-1-2013	Amend	2-1-2013
635-004-0350	1-1-2013	Amend	2-1-2013
635-004-0355	1-1-2013	Amend	2-1-2013
635-004-0375	6-19-2013	Amend	8-1-2013
635-004-0465	1-1-2013	Amend	2-1-2013
635-004-0485	5-14-2013	Amend	6-1-2013
635-004-0585	5-14-2013	Amend	6-1-2013
635-005-0320	5-14-2013	Amend	6-1-2013
635-005-0355	6-15-2013	Amend(T)	7-1-2013
635-005-0410	1-1-2013	Amend	2-1-2013
635-005-0430	5-14-2013	Amend	6-1-2013
635-005-0465	12-12-2012	Amend(T)	1-1-2013
635-005-0465(T)	12-12-2012	Suspend	1-1-2013
635-005-0480	1-1-2013	Amend	2-1-2013
635-005-0585	1-1-2013	Amend	2-1-2013
635-005-0605	5-14-2013	Amend	6-1-2013
635-005-0660	5-14-2013	Amend	6-1-2013
635-005-0665	5-14-2013	Amend	6-1-2013
635-005-0740	1-1-2013	Amend	2-1-2013
635-005-0745	5-14-2013	Amend	6-1-2013
635-005-0760	5-14-2013	Amend	6-1-2013
635-005-0800	1-1-2013	Amend	2-1-2013
635-005-0820	5-14-2013	Amend	6-1-2013
635-005-0825	5-14-2013	Amend	6-1-2013
635-006-0001	1-1-2013	Amend	2-1-2013
635-006-0001	5-14-2013	Amend	6-1-2013
635-006-0165	5-14-2013	Amend	6-1-2013
635-006-0200	1-1-2013	Amend	2-1-2013
635-006-0210	1-1-2013	Amend	2-1-2013
635-006-0211	1-1-2013	Amend	2-1-2013
635-006-0212	7-3-2013	Amend(T)	8-1-2013
635-006-0215	1-1-2013	Amend	2-1-2013
635-006-0215	7-3-2013	Amend(T)	8-1-2013
635-006-0225	7-3-2013	Amend(T)	8-1-2013
635-006-0232	1-14-2013	Amend	2-1-2013
635-006-1025	5-14-2013	Amend	6-1-2013
635-006-1075	5-14-2013	Amend	6-1-2013
635-008-0151	5-10-2013	Amend	6-1-2013
635-008-0151(T)	5-10-2013	Repeal	6-1-2013
635-008-0175	1-1-2013	Amend	2-1-2013
635-011-0100	1-1-2013	Amend	2-1-2013
635-011-0102	1-1-2013	Amend	2-1-2013
635-013-0003	1-1-2013	Amend	2-1-2013
635-013-0003	5-1-2013	Amend(T)	6-1-2013
635-013-0003	5-14-2013	Amend	6-1-2013
635-013-0003(T)	5-14-2013	Repeal	6-1-2013
635-013-0004	1-1-2013	Amend	2-1-2013
635-013-0007	7-1-2013	Amend	7-1-2013
635-013-0009	7-1-2013	Amend	7-1-2013
635-014-0080	1-1-2013	Amend	2-1-2013
635-014-0090	1-1-2013	Amend	2-1-2013
635-014-0090	4-1-2013	Amend(T)	5-1-2013
635-014-0090	6-1-2013	Amend(T)	7-1-2013
635-014-0090	6-30-2013	Amend(T)	8-1-2013
635-014-0090	7-1-2013	Amend	7-1-2013
635-014-0090(T)	6-1-2013	Suspend	7-1-2013
635-014-0090(T)	7-1-2013	Repeal	7-1-2013
635-016-0080	1-1-2013	Amend	2-1-2013
635-016-0090	1-1-2013	Amend	2-1-2013
635-016-0090	1-1-2013	Amend(T)	2-1-2013
635-016-0090	4-1-2013	Amend(T)	5-1-2013
635-016-0090	7-1-2013	Amend	7-1-2013
635-016-0090(T)	4-1-2013	Suspend	5-1-2013
635-016-0090(T)	7-1-2013	Repeal	7-1-2013
635-017-0080	1-1-2013	Amend	2-1-2013
635-017-0090	1-1-2013	Amend	2-1-2013
635-017-0090	7-11-2013	Amend(T)	8-1-2013
635-017-0095	1-1-2013	Amend	2-1-2013
635-017-0095	2-14-2013	Amend(T)	3-1-2013
635-017-0095	2-28-2013	Amend(T)	4-1-2013
635-017-0095	4-1-2013	Amend(T)	5-1-2013
635-017-0095(T)	4-1-2013	Suspend	5-1-2013
635-018-0080	1-1-2013	Amend	2-1-2013
635-018-0090	1-1-2013	Amend	2-1-2013
635-018-0090	4-15-2013	Amend(T)	4-1-2013
635-018-0090	8-1-2013	Amend(T)	8-1-2013
635-019-0080	1-1-2013	Amend	2-1-2013
635-019-0090	1-1-2013	Amend	2-1-2013
635-019-0090	1-1-2013	Amend(T)	2-1-2013
635-019-0090	5-16-2013	Amend(T)	6-1-2013
635-019-0090	5-24-2013	Amend(T)	7-1-2013
635-019-0090	6-1-2013	Amend(T)	7-1-2013
635-019-0090	7-5-2013	Amend(T)	8-1-2013
635-019-0090	7-19-2013	Amend(T)	8-1-2013
635-019-0090(T)	5-24-2013	Suspend	7-1-2013
635-019-0090(T)	6-1-2013	Suspend	7-1-2013
635-019-0090(T)	7-5-2013	Suspend	8-1-2013
635-019-0090(T)	7-19-2013	Suspend	8-1-2013
635-021-0080	1-1-2013	Amend	2-1-2013
635-021-0090	1-1-2013	Amend	2-1-2013
635-021-0090	7-1-2013	Amend(T)	8-1-2013
635-023-0080	1-1-2013	Amend	2-1-2013
635-023-0090	1-1-2013	Amend	2-1-2013
635-023-0095	1-1-2013	Amend	2-1-2013
635-023-0095	1-1-2013	Amend(T)	2-1-2013
635-023-0095	2-28-2013	Amend(T)	3-1-2013
635-023-0095	4-1-2013	Amend(T)	5-1-2013
635-023-0095	6-14-2013	Amend(T)	7-1-2013
635-023-0095	6-21-2013	Amend(T)	8-1-2013
635-023-0095	6-29-2013	Amend(T)	8-1-2013
635-023-0095(T)	2-28-2013	Suspend	3-1-2013
635-023-0095(T)	4-1-2013	Suspend	5-1-2013
635-023-0095(T)	6-14-2013	Suspend	7-1-2013
635-023-0095(T)	6-21-2013	Suspend	8-1-2013
635-023-0095(T)	6-29-2013	Suspend	8-1-2013
635-023-0125	1-1-2013	Amend	2-1-2013
635-023-0125	2-28-2013	Amend(T)	3-1-2013
635-023-0125	4-5-2013	Amend(T)	5-1-2013
635-023-0125	5-25-2013	Amend(T)	7-1-2013

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635-023-0125(T)	5-25-2013	Suspend	7-1-2013
635-023-0125(T)	6-8-2013	Suspend	7-1-2013
635-023-0128	1-1-2013	Amend	2-1-2013
635-023-0128	6-16-2013	Amend(T)	7-1-2013
635-023-0128	6-27-2013	Amend(T)	8-1-2013
635-023-0128	7-13-2013	Amend(T)	8-1-2013
635-023-0128(T)	6-27-2013	Suspend	8-1-2013
635-023-0128(T)	7-13-2013	Suspend	8-1-2013
635-023-0130	1-1-2013	Amend	2-1-2013
635-023-0134	1-1-2013	Amend	2-1-2013
635-023-0134	5-4-2013	Amend(T)	6-1-2013
635-039-0080	1-3-2013	Amend	2-1-2013
635-039-0080	5-1-2013	Amend(T)	5-1-2013
635-039-0080	5-14-2013	Amend	6-1-2013
635-039-0080(T)	5-14-2013	Repeal	6-1-2013
635-039-0085	6-28-2013	Amend(T)	8-1-2013
635-039-0090	1-1-2013	Amend	2-1-2013
635-039-0090	1-1-2013	Amend(T)	2-1-2013
635-039-0090	4-1-2013	Amend(T)	5-1-2013
635-039-0090	5-14-2013	Amend	6-1-2013
635-039-0090(T)	4-1-2013	Suspend	5-1-2013
635-039-0090(T)	5-14-2013	Repeal	6-1-2013
635-041-0020	1-1-2013	Amend	2-1-2013
635-041-0045	2-1-2013	Amend(T)	3-1-2013
635-041-0045	3-6-2013	Amend(T)	4-1-2013
635-041-0045	6-16-2013	Amend(T)	7-1-2013
635-041-0045(T)	3-6-2013	Suspend	4-1-2013
635-041-0045(T)	6-16-2013	Suspend	7-1-2013
635-041-0063	5-24-2013	Amend(T)	7-1-2013
635-041-0065	2-1-2013	Amend(T)	3-1-2013
635-041-0065	2-27-2013	Amend(T)	4-1-2013
635-041-0065	3-6-2013	Amend(T)	4-1-2013
635-041-0065	5-21-2013	Amend(T)	7-1-2013
635-041-0065	6-8-2013	Amend(T)	7-1-2013
635-041-0065(T)	2-27-2013	Suspend	4-1-2013
635-041-0065(T)	3-6-2013	Suspend	4-1-2013
635-041-0065(T)	5-21-2013	Suspend	7-1-2013
635-041-0065(T)	6-8-2013	Suspend	7-1-2013
635-041-0065(T)	6-16-2013	Suspend	7-1-2013
635-041-0076	6-16-2013	Amend(T)	7-1-2013
635-041-0076	6-29-2013	Amend(T)	8-1-2013
635-041-0076	7-6-2013	Amend(T)	8-1-2013
635-041-0076	7-15-2013	Amend(T)	8-1-2013
635-041-0076(T)	6-29-2013	Suspend	8-1-2013
635-041-0076(T)	7-6-2013	Suspend	8-1-2013
635-041-0076(T)	7-15-2013	Suspend	8-1-2013
635-042-0022	4-9-2013	Amend(T)	5-1-2013
635-042-0022	5-15-2013	Amend(T)	6-1-2013
635-042-0022	5-22-2013	Amend(T)	7-1-2013
635-042-0022	5-29-2013	Amend(T)	7-1-2013
635-042-0022(T)	5-22-2013	Suspend	7-1-2013
635-042-0022(T)	5-29-2013	Suspend	7-1-2013
635-042-0027	6-16-2013	Amend(T)	7-1-2013
635-042-0027	7-15-2013	Amend(T)	8-1-2013
635-042-0027(T)	7-15-2013	Suspend	8-1-2013
635-042-0135	1-31-2013	Amend(T)	3-1-2013
635-042-0145	2-11-2013	Amend(T)	3-1-2013
635-042-0145	3-13-2013	Amend(T)	4-1-2013
635-042-0145	5-15-2013	Amend(T)	6-1-2013
635-042-0145	5-22-2013	Amend(T)	7-1-2013
635-042-0145	5-29-2013	Amend(T)	7-1-2013
635-042-0145(T)	3-13-2013	Suspend	4-1-2013
635-042-0145(T)	5-15-2013	Suspend	6-1-2013
635-042-0145(T)	5-22-2013	Suspend	7-1-2013
635-042-0145(T)	5-29-2013	Suspend	7-1-2013
635-042-0160	2-11-2013	Amend(T)	3-1-2013
635-042-0160	3-21-2013	Amend(T)	5-1-2013
635-042-0160(T)	3-21-2013	Suspend	5-1-2013
635-042-0170	2-11-2013	Amend(T)	3-1-2013
635-042-0170	5-15-2013	Amend(T)	6-1-2013
635-042-0170(T)	5-15-2013	Suspend	6-1-2013
635-042-0180	2-11-2013	Amend(T)	3-1-2013
635-042-0180	3-21-2013	Amend(T)	5-1-2013
635-042-0180(T)	3-21-2013	Suspend	5-1-2013
635-043-0051	6-10-2013	Amend	7-1-2013
635-045-0000	1-1-2013	Amend	2-1-2013
635-045-0002	1-1-2013	Amend	2-1-2013
635-050-0050	6-10-2013	Amend	7-1-2013
635-053-0035	1-23-2013	Amend(T)	3-1-2013
635-056-0050	12-18-2012	Amend	2-1-2013
635-056-0075	12-18-2012	Amend	2-1-2013
635-060-0005	1-23-2013	Amend	3-1-2013
635-060-0040	3-11-2013	Amend(T)	4-1-2013
635-065-0001	1-1-2013	Amend	2-1-2013
635-065-0011	1-1-2013	Adopt	2-1-2013
635-065-0011	2-7-2013	Amend	3-1-2013
635-065-0015	1-1-2013	Amend	2-1-2013
635-065-0090	1-1-2013	Amend	2-1-2013
635-065-0401	1-1-2013	Amend	2-1-2013
635-065-0625	1-1-2013	Amend	2-1-2013
635-065-0735	1-1-2013	Amend	2-1-2013
635-065-0740	1-1-2013	Amend	2-1-2013
635-065-0760	1-1-2013	Amend	2-1-2013
635-065-0765	2-1-2013	Amend	2-1-2013
635-065-0765	2-7-2013	Amend	3-1-2013
635-065-0765(T)	2-7-2013	Repeal	3-1-2013
635-066-0000	1-1-2013	Amend	2-1-2013
635-066-0010	1-1-2013	Amend	2-1-2013
635-066-0020	1-1-2013	Amend	2-1-2013
635-067-0000	1-1-2013	Amend	2-1-2013
635-067-0000	6-10-2013	Amend	7-1-2013
635-067-0004	1-1-2013	Amend	2-1-2013
635-068-0000	3-1-2013	Amend	3-1-2013
635-068-0000	6-10-2013	Amend	7-1-2013
635-069-0000	2-1-2013	Amend	2-1-2013
635-069-0000	6-10-2013	Amend	7-1-2013
635-070-0000	4-1-2013	Amend	4-1-2013
635-070-0000	6-10-2013	Amend	7-1-2013
635-070-0020	2-7-2013	Amend	3-1-2013
635-071-0000	4-1-2013	Amend	4-1-2013

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635-073-0000	2-1-2013	Amend	2-1-2013
635-073-0000	6-10-2013	Amend	7-1-2013
635-073-0065	2-1-2013	Amend	2-1-2013
635-073-0070	2-1-2013	Amend	2-1-2013
635-075-0005	3-11-2013	Amend(T)	4-1-2013
635-075-0005	6-10-2013	Amend	7-1-2013
635-075-0005(T)	6-10-2013	Repeal	7-1-2013
635-078-0011	1-1-2013	Amend	2-1-2013
635-095-0125	12-31-2012	Amend(T)	2-1-2013
635-095-0125	6-10-2013	Amend	7-1-2013
635-095-0125(T)	6-10-2013	Repeal	7-1-2013
635-110-0009	5-23-2013	Adopt(T)	7-1-2013
635-110-0010	5-23-2013	Amend(T)	7-1-2013
635-110-0010	7-12-2013	Amend	8-1-2013
635-110-0010(T)	7-12-2013	Repeal	8-1-2013
635-110-0020	5-23-2013	Amend(T)	7-1-2013
635-110-0020	7-12-2013	Amend	8-1-2013
635-110-0020(T)	7-12-2013	Repeal	8-1-2013
635-500-6650	1-14-2013	Adopt	2-1-2013
635-500-6700	1-1-2013	Adopt	2-1-2013
635-500-6705	1-1-2013	Adopt	2-1-2013
635-500-6710	1-1-2013	Adopt	2-1-2013
635-500-6715	1-1-2013	Adopt	2-1-2013
635-500-6720	1-1-2013	Adopt	2-1-2013
635-500-6725	1-1-2013	Adopt	2-1-2013
635-500-6730	1-1-2013	Adopt	2-1-2013
635-500-6735	1-1-2013	Adopt	2-1-2013
635-500-6740	1-1-2013	Adopt	2-1-2013
635-500-6745	1-1-2013	Adopt	2-1-2013
635-500-6750	1-1-2013	Adopt	2-1-2013
635-500-6755	1-1-2013	Adopt	2-1-2013
635-500-6760	1-1-2013	Adopt	2-1-2013
635-500-6765	1-1-2013	Adopt	2-1-2013
645-010-0015	7-5-2013	Amend	8-1-2013
645-040-0010	7-5-2013	Amend	8-1-2013
647-010-0010	5-10-2013	Amend	6-1-2013
658-030-0020	7-3-2013	Amend	8-1-2013
660-006-0005	2-1-2013	Amend	3-1-2013
660-006-0025	2-1-2013	Amend	3-1-2013
660-024-0040	12-10-2012	Amend	1-1-2013
660-024-0045	12-10-2012	Adopt	1-1-2013
660-033-0130	1-29-2013	Amend	3-1-2013
660-044-0000	1-1-2013	Amend	1-1-2013
660-044-0005	1-1-2013	Amend	1-1-2013
660-044-0040	1-1-2013	Adopt	1-1-2013
660-044-0045	1-1-2013	Adopt	1-1-2013
660-044-0050	1-1-2013	Adopt	1-1-2013
660-044-0055	1-1-2013	Adopt	1-1-2013
660-044-0060	1-1-2013	Adopt	1-1-2013
661-010-0075	5-1-2013	Amend(T)	6-1-2013
668-010-0010	5-15-2013	Amend	6-1-2013
690-022-0005	7-1-2013	Adopt(T)	8-1-2013
690-022-0010	7-1-2013	Adopt(T)	8-1-2013
690-022-0015	7-1-2013	Adopt(T)	8-1-2013
690-501-0005	12-12-2012	Amend	1-1-2013
690-501-0010	12-12-2012	Amend	1-1-2013
690-501-0020	12-12-2012	Repeal	1-1-2013
690-501-0030	12-12-2012	Amend	1-1-2013
690-515-0000	12-12-2012	Amend	1-1-2013
690-515-0010	12-12-2012	Amend	1-1-2013
690-515-0020	12-12-2012	Amend	1-1-2013
690-515-0030	12-12-2012	Amend	1-1-2013
690-515-0040	12-12-2012	Amend	1-1-2013
690-515-0050	12-12-2012	Amend	1-1-2013
690-515-0060	12-12-2012	Amend	1-1-2013
690-516-0005	12-12-2012	Amend	1-1-2013
690-516-0010	12-12-2012	Amend	1-1-2013
690-516-0020	12-12-2012	Repeal	1-1-2013
690-516-0030	12-12-2012	Amend	1-1-2013
690-517-0000	12-12-2012	Amend	1-1-2013
690-517-0020	12-12-2012	Amend	1-1-2013
690-517-0030	12-12-2012	Amend	1-1-2013
690-517-0040	12-12-2012	Amend	1-1-2013
690-517-0050	12-12-2012	Repeal	1-1-2013
690-518-0010	12-12-2012	Amend	1-1-2013
690-518-0030	12-12-2012	Amend	1-1-2013
690-518-0040	12-12-2012	Repeal	1-1-2013
690-518-0050	12-12-2012	Amend	1-1-2013
695-045-0010	1-30-2013	Amend	3-1-2013
695-045-0020	1-30-2013	Amend	3-1-2013
695-045-0025	1-30-2013	Repeal	3-1-2013
695-045-0030	1-30-2013	Repeal	3-1-2013
695-045-0035	1-30-2013	Repeal	3-1-2013
695-045-0040	1-30-2013	Repeal	3-1-2013
695-045-0045	1-30-2013	Repeal	3-1-2013
695-045-0050	1-30-2013	Repeal	3-1-2013
695-045-0055	1-30-2013	Repeal	3-1-2013
695-045-0060	1-30-2013	Repeal	3-1-2013
695-045-0065	1-30-2013	Repeal	3-1-2013
695-045-0070	1-30-2013	Repeal	3-1-2013
695-045-0080	1-30-2013	Repeal	3-1-2013
695-045-0090	1-30-2013	Repeal	3-1-2013
695-045-0100	1-30-2013	Repeal	3-1-2013
695-045-0110	1-30-2013	Repeal	3-1-2013
695-045-0120	1-30-2013	Repeal	3-1-2013
695-045-0130	1-30-2013	Repeal	3-1-2013
695-045-0140	1-30-2013	Repeal	3-1-2013
695-045-0150	1-30-2013	Repeal	3-1-2013
695-045-0160	1-30-2013	Adopt	3-1-2013
695-045-0165	1-30-2013	Adopt	3-1-2013
695-045-0170	1-30-2013	Adopt	3-1-2013
695-045-0175	1-30-2013	Adopt	3-1-2013
695-045-0180	1-30-2013	Adopt	3-1-2013
695-045-0185	1-30-2013	Adopt	3-1-2013
695-045-0190	1-30-2013	Adopt	3-1-2013
695-045-0195	1-30-2013	Adopt	3-1-2013
695-045-0200	1-30-2013	Adopt	3-1-2013
695-045-0205	1-30-2013	Adopt	3-1-2013
695-045-0210	1-30-2013	Adopt	3-1-2013
695-045-0215	1-30-2013	Adopt	3-1-2013

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695-046-0025	6-19-2013	Repeal	8-1-2013
695-046-0030	6-19-2013	Repeal	8-1-2013
695-046-0040	6-19-2013	Repeal	8-1-2013
695-046-0050	6-19-2013	Repeal	8-1-2013
695-046-0060	6-19-2013	Repeal	8-1-2013
695-046-0070	6-19-2013	Repeal	8-1-2013
695-046-0080	6-19-2013	Repeal	8-1-2013
695-046-0090	6-19-2013	Repeal	8-1-2013
695-046-0100	6-19-2013	Repeal	8-1-2013
695-046-0110	6-19-2013	Repeal	8-1-2013
695-046-0120	6-19-2013	Repeal	8-1-2013
695-046-0130	6-19-2013	Repeal	8-1-2013
695-046-0140	6-19-2013	Repeal	8-1-2013
695-046-0150	6-19-2013	Repeal	8-1-2013
695-046-0160	6-19-2013	Repeal	8-1-2013
695-046-0170	6-19-2013	Repeal	8-1-2013
695-046-0175	6-19-2013	Adopt	8-1-2013
695-046-0180	6-19-2013	Adopt	8-1-2013
695-046-0185	6-19-2013	Adopt	8-1-2013
695-046-0190	6-19-2013	Adopt	8-1-2013
695-046-0195	6-19-2013	Adopt	8-1-2013
695-046-0200	6-19-2013	Adopt	8-1-2013
695-046-0205	6-19-2013	Adopt	8-1-2013
695-046-0210	6-19-2013	Adopt	8-1-2013
695-046-0215	6-19-2013	Adopt	8-1-2013
695-046-0220	6-19-2013	Adopt	8-1-2013
695-046-0225	6-19-2013	Adopt	8-1-2013
695-046-0230	6-19-2013	Adopt	8-1-2013
705-010-0070	5-2-2013	Amend	6-1-2013
731-001-0000	5-17-2013	Amend	7-1-2013
731-070-0050	6-21-2013	Amend	8-1-2013
733-001-0000	4-15-2013	Amend	5-1-2013
733-001-0005	4-15-2013	Amend	5-1-2013
733-001-0010	4-15-2013	Adopt	5-1-2013
733-001-0015	4-15-2013	Adopt	5-1-2013
733-001-0025	4-15-2013	Adopt	5-1-2013
733-001-0030	4-15-2013	Adopt	5-1-2013
733-001-0035	4-15-2013	Adopt	5-1-2013
734-010-0220	11-21-2012	Amend	1-1-2013
734-010-0290	11-21-2012	Amend	1-1-2013
734-010-0300	11-21-2012	Amend	1-1-2013
734-010-0310	11-21-2012	Repeal	1-1-2013
734-010-0320	11-21-2012	Amend	1-1-2013
734-010-0330	11-21-2012	Amend	1-1-2013
734-010-0340	11-21-2012	Amend	1-1-2013
734-010-0350	11-21-2012	Amend	1-1-2013
734-010-0370	11-21-2012	Repeal	1-1-2013
734-010-0380	11-21-2012	Amend	1-1-2013
734-030-0005	3-1-2013	Amend	3-1-2013
734-030-0010	3-1-2013	Amend	3-1-2013
734-030-0015	3-1-2013	Amend	3-1-2013
734-030-0016	3-1-2013	Adopt	3-1-2013
734-059-0100	11-20-2012	Amend	1-1-2013
734-073-0090	12-21-2012	Repeal	2-1-2013
734-075-0010	5-16-2013	Amend	7-1-2013
734-075-0011	5-16-2013	Amend	7-1-2013
735-001-0050	3-22-2013	Amend	5-1-2013
735-001-0062	1-1-2013	Adopt	2-1-2013
735-001-0062	5-3-2013	Adopt	6-1-2013
735-012-0000	11-19-2012	Amend	1-1-2013
735-012-0000(T)	11-19-2012	Repeal	1-1-2013
735-048-0000	4-22-2013	Amend	6-1-2013
735-048-0020	4-22-2013	Amend	6-1-2013
735-048-0030	4-22-2013	Amend	6-1-2013
735-048-0040	4-22-2013	Amend	6-1-2013
735-048-0050	4-22-2013	Amend	6-1-2013
735-048-0060	4-22-2013	Amend	6-1-2013
735-048-0070	4-22-2013	Amend	6-1-2013
735-048-0080	4-22-2013	Amend	6-1-2013
735-050-0100	5-23-2013	Amend	7-1-2013
735-050-0120	6-21-2013	Amend(T)	8-1-2013
735-062-0080	2-1-2013	Amend	3-1-2013
735-064-0005	3-22-2013	Amend	5-1-2013
735-064-0020	3-22-2013	Amend	5-1-2013
735-064-0060	3-22-2013	Amend	5-1-2013
735-064-0100	3-22-2013	Amend	5-1-2013
735-064-0110	3-22-2013	Amend	5-1-2013
735-070-0006	11-19-2012	Adopt	1-1-2013
735-070-0080	5-23-2013	Amend	7-1-2013
735-070-0085	6-21-2013	Amend(T)	8-1-2013
735-072-0020	5-1-2013	Amend	6-1-2013
735-072-0023	5-1-2013	Amend	6-1-2013
735-164-0000	5-23-2013	Amend	7-1-2013
735-164-0010	5-23-2013	Amend	7-1-2013
735-164-0020	5-23-2013	Amend	7-1-2013
736-010-0060	11-16-2012	Amend	1-1-2013
736-015-0006	11-16-2012	Amend	1-1-2013
736-015-0015	11-16-2012	Amend	1-1-2013
736-018-0045	12-31-2012	Amend	1-1-2013
736-021-0010	2-1-2013	Amend	2-1-2013
736-021-0020	2-1-2013	Amend	2-1-2013
736-021-0030	2-1-2013	Amend	2-1-2013
736-021-0040	2-1-2013	Amend	2-1-2013
736-021-0050	2-1-2013	Amend	2-1-2013
736-021-0060	2-1-2013	Amend	2-1-2013
736-021-0065	2-1-2013	Adopt	2-1-2013
736-021-0070	2-1-2013	Amend	2-1-2013
736-021-0080	2-1-2013	Amend	2-1-2013
736-021-0090	2-1-2013	Amend	2-1-2013
736-021-0100	2-1-2013	Amend	2-1-2013
736-021-0110	2-1-2013	Repeal	2-1-2013
736-021-0120	2-1-2013	Amend	2-1-2013
736-021-0130	2-1-2013	Amend	2-1-2013
736-021-0140	2-1-2013	Amend	2-1-2013
736-021-0150	2-1-2013	Amend	2-1-2013
736-021-0160	2-1-2013	Amend	2-1-2013
736-045-0006	12-13-2012	Adopt	1-1-2013
736-045-0011	12-13-2012	Adopt	1-1-2013
736-045-0100	12-13-2012	Adopt	1-1-2013
736-045-0200	12-13-2012	Adopt	1-1-2013

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736-045-0305	12-13-2012	Adopt	1-1-2013
736-045-0310	12-13-2012	Adopt	1-1-2013
736-045-0320	12-13-2012	Adopt	1-1-2013
736-045-0330	12-13-2012	Adopt	1-1-2013
736-045-0340	12-13-2012	Adopt	1-1-2013
736-045-0400	12-13-2012	Adopt	1-1-2013
736-045-0405	12-13-2012	Adopt	1-1-2013
736-045-0410	12-13-2012	Adopt	1-1-2013
736-045-0412	12-13-2012	Adopt	1-1-2013
736-045-0414	12-13-2012	Adopt	1-1-2013
736-045-0416	12-13-2012	Adopt	1-1-2013
736-045-0418	12-13-2012	Adopt	1-1-2013
736-045-0420	12-13-2012	Adopt	1-1-2013
736-045-0422	12-13-2012	Adopt	1-1-2013
736-045-0424	12-13-2012	Adopt	1-1-2013
736-045-0426	12-13-2012	Adopt	1-1-2013
736-045-0428	12-13-2012	Adopt	1-1-2013
736-045-0430	12-13-2012	Adopt	1-1-2013
736-045-0432	12-13-2012	Adopt	1-1-2013
736-045-0434	12-13-2012	Adopt	1-1-2013
736-045-0436	12-13-2012	Adopt	1-1-2013
736-045-0438	12-13-2012	Adopt	1-1-2013
736-045-0440	12-13-2012	Adopt	1-1-2013
736-045-0442	12-13-2012	Adopt	1-1-2013
736-045-0444	12-13-2012	Adopt	1-1-2013
736-045-0446	12-13-2012	Adopt	1-1-2013
736-045-0448	12-13-2012	Adopt	1-1-2013
736-045-0500	12-13-2012	Adopt	1-1-2013
736-045-0505	12-13-2012	Adopt	1-1-2013
740-055-0035	5-16-2013	Adopt	7-1-2013
740-060-0010	6-20-2013	Amend	8-1-2013
740-060-0020	6-20-2013	Amend	8-1-2013
740-060-0030	1-18-2013	Amend(T)	3-1-2013
740-060-0030	6-20-2013	Repeal	8-1-2013
740-060-0035	6-20-2013	Adopt	8-1-2013
740-060-0040	1-18-2013	Amend(T)	3-1-2013
740-060-0040	6-20-2013	Amend	8-1-2013
740-060-0040(T)	6-20-2013	Repeal	8-1-2013
740-060-0045	6-20-2013	Amend	8-1-2013
740-060-0055	6-20-2013	Amend	8-1-2013
740-060-0060	6-20-2013	Amend	8-1-2013
740-060-0070	6-20-2013	Amend	8-1-2013
740-060-0080	1-18-2013	Amend(T)	3-1-2013
740-060-0080	6-20-2013	Amend	8-1-2013
740-060-0080(T)	6-20-2013	Repeal	8-1-2013
740-060-0085	6-20-2013	Adopt	8-1-2013
740-060-0090	6-20-2013	Adopt	8-1-2013
740-060-0100	6-20-2013	Amend	8-1-2013
740-060-0110	6-20-2013	Amend	8-1-2013
740-100-0010	4-22-2013	Amend	6-1-2013
740-100-0065	4-22-2013	Amend	6-1-2013
740-100-0070	4-22-2013	Amend	6-1-2013
740-100-0080	4-22-2013	Amend	6-1-2013
740-100-0085	4-22-2013	Amend	6-1-2013
740-100-0090	4-22-2013	Amend	6-1-2013
740-110-0010	4-22-2013	Amend	6-1-2013
740-200-0010	1-17-2013	Amend	3-1-2013
740-200-0020	1-17-2013	Amend	3-1-2013
740-200-0040	1-17-2013	Amend	3-1-2013
800-001-0020	2-1-2013	Amend	2-1-2013
800-010-0020	2-1-2013	Amend	2-1-2013
800-010-0030	2-1-2013	Amend	2-1-2013
800-015-0010	2-1-2013	Amend	2-1-2013
800-020-0015	2-1-2013	Amend	2-1-2013
800-020-0030	2-1-2013	Amend	2-1-2013
800-020-0035	2-1-2013	Amend	2-1-2013
800-030-0025	2-1-2013	Amend	2-1-2013
801-001-0035	1-8-2013	Amend	2-1-2013
804-001-0002	7-1-2013	Amend	7-1-2013
804-003-0000	6-20-2013	Amend(T)	8-1-2013
804-010-0000	11-21-2012	Amend	1-1-2013
804-010-0000(T)	11-21-2012	Repeal	1-1-2013
804-020-0001	11-21-2012	Amend	1-1-2013
804-020-0001(T)	11-21-2012	Repeal	1-1-2013
804-020-0003	11-21-2012	Amend	1-1-2013
804-020-0003(T)	11-21-2012	Repeal	1-1-2013
804-020-0010	11-21-2012	Amend	1-1-2013
804-020-0010(T)	11-21-2012	Repeal	1-1-2013
804-020-0015	11-21-2012	Amend	1-1-2013
804-020-0015(T)	11-21-2012	Repeal	1-1-2013
804-020-0030	11-21-2012	Amend	1-1-2013
804-020-0030(T)	11-21-2012	Repeal	1-1-2013
804-020-0040	11-21-2012	Amend	1-1-2013
804-020-0040(T)	11-21-2012	Repeal	1-1-2013
804-020-0045	11-21-2012	Amend	1-1-2013
804-020-0045(T)	11-21-2012	Repeal	1-1-2013
804-020-0065	11-21-2012	Amend	1-1-2013
804-020-0065(T)	11-21-2012	Repeal	1-1-2013
804-022-0005	6-20-2013	Amend(T)	8-1-2013
804-022-0010	6-20-2013	Amend(T)	8-1-2013
804-025-0010	6-20-2013	Amend(T)	8-1-2013
804-040-0000	11-21-2012	Amend	1-1-2013
804-040-0000(T)	11-21-2012	Repeal	1-1-2013
806-001-0003	7-1-2013	Amend	5-1-2013
806-010-0090	12-31-2012	Amend	2-1-2013
806-010-0105	2-12-2013	Amend	3-1-2013
808-001-0008	7-1-2013	Amend	8-1-2013
808-002-0020	12-4-2012	Amend	1-1-2013
808-002-0755	2-1-2013	Adopt	3-1-2013
808-003-0045	6-1-2013	Amend	7-1-2013
808-003-0060	6-1-2013	Amend	7-1-2013
808-005-0020	12-4-2012	Amend	1-1-2013
808-040-0025	12-4-2012	Amend	1-1-2013
808-040-0050	12-4-2012	Amend	1-1-2013
808-040-0060	12-4-2012	Amend	1-1-2013
809-001-0000	12-21-2012	Amend	1-1-2013
809-001-0020	12-21-2012	Repeal	1-1-2013
809-001-0025	12-21-2012	Repeal	1-1-2013
809-001-0030	12-21-2012	Repeal	1-1-2013
809-010-0025	12-21-2012	Amend	1-1-2013
809-010-0025	7-1-2013	Amend	7-1-2013

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812-005-0180	5-1-2013	Amend	6-1-2013
812-006-0100	5-1-2013	Amend	6-1-2013
812-006-0150	5-1-2013	Amend	6-1-2013
812-006-0200	5-1-2013	Amend	6-1-2013
812-006-0250	5-1-2013	Amend	6-1-2013
812-006-0300	5-1-2013	Amend	6-1-2013
812-006-0350	5-1-2013	Amend	6-1-2013
812-006-0400	5-1-2013	Amend	6-1-2013
812-006-0450	5-1-2013	Amend	6-1-2013
813-001-0007	6-21-2013	Amend(T)	8-1-2013
813-004-0001	3-28-2013	Adopt	5-1-2013
813-004-0001(T)	3-28-2013	Repeal	5-1-2013
813-004-0002	3-28-2013	Adopt	5-1-2013
813-004-0002(T)	3-28-2013	Repeal	5-1-2013
813-004-0200	1-4-2013	Adopt	2-1-2013
813-004-0210	1-4-2013	Adopt	2-1-2013
813-004-0220	1-4-2013	Adopt	2-1-2013
813-004-0230	1-4-2013	Adopt	2-1-2013
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813-004-0260	1-4-2013	Adopt	2-1-2013
813-004-0270	1-4-2013	Adopt	2-1-2013
813-004-0280	1-4-2013	Adopt	2-1-2013
813-004-0290	1-4-2013	Adopt	2-1-2013
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813-004-0310	1-4-2013	Adopt	2-1-2013
813-005-0001	6-21-2013	Amend(T)	8-1-2013
813-005-0005	6-21-2013	Amend(T)	8-1-2013
813-005-0016	6-21-2013	Amend(T)	8-1-2013
813-005-0020	6-21-2013	Adopt(T)	8-1-2013
813-005-0030	6-21-2013	Adopt(T)	8-1-2013
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813-005-0050	6-21-2013	Adopt(T)	8-1-2013
813-005-0060	6-21-2013	Adopt(T)	8-1-2013
813-005-0070	6-21-2013	Adopt(T)	8-1-2013
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813-006-0015	6-21-2013	Amend(T)	8-1-2013
813-006-0020	6-21-2013	Amend(T)	8-1-2013
813-006-0025	6-21-2013	Amend(T)	8-1-2013
813-006-0030	6-21-2013	Amend(T)	8-1-2013
813-006-0035	6-21-2013	Amend(T)	8-1-2013
813-006-0040	6-21-2013	Adopt(T)	8-1-2013
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813-007-0040	3-21-2013	Amend(T)	5-1-2013
813-055-0001	6-21-2013	Amend(T)	8-1-2013
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813-055-0020	6-21-2013	Amend(T)	8-1-2013
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813-055-0060	6-21-2013	Suspend	8-1-2013
813-055-0065	6-21-2013	Adopt(T)	8-1-2013
813-055-0070	6-21-2013	Renumber	8-1-2013
813-055-0075	6-21-2013	Amend(T)	8-1-2013
813-055-0080	6-21-2013	Renumber	8-1-2013
813-055-0085	6-21-2013	Amend(T)	8-1-2013
813-055-0090	6-21-2013	Renumber	8-1-2013
813-055-0095	6-21-2013	Adopt(T)	8-1-2013
813-055-0100	6-21-2013	Suspend	8-1-2013
813-055-0105	6-21-2013	Amend(T)	8-1-2013
813-055-0110	6-21-2013	Suspend	8-1-2013
813-055-0115	6-21-2013	Amend(T)	8-1-2013
813-090-0005	6-21-2013	Amend(T)	8-1-2013
813-090-0010	6-21-2013	Amend(T)	8-1-2013
813-090-0015	6-21-2013	Amend(T)	8-1-2013
813-090-0025	6-21-2013	Renumber	8-1-2013
813-090-0027	6-21-2013	Suspend	8-1-2013
813-090-0029	6-21-2013	Renumber	8-1-2013
813-090-0030	6-21-2013	Renumber	8-1-2013
813-090-0031	6-21-2013	Suspend	8-1-2013
813-090-0035	6-21-2013	Amend(T)	8-1-2013
813-090-0036	6-21-2013	Suspend	8-1-2013
813-090-0037	6-21-2013	Amend(T)	8-1-2013
813-090-0039	6-21-2013	Amend(T)	8-1-2013
813-090-0040	6-21-2013	Amend(T)	8-1-2013
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813-090-0048	6-21-2013	Adopt(T)	8-1-2013
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813-090-0065	6-21-2013	Suspend	8-1-2013
813-090-0067	6-21-2013	Amend(T)	8-1-2013
813-090-0070	6-21-2013	Renumber	8-1-2013
813-090-0075	6-21-2013	Adopt(T)	8-1-2013
813-090-0080	6-21-2013	Amend(T)	8-1-2013
813-090-0090	6-21-2013	Adopt(T)	8-1-2013
813-090-0095	6-21-2013	Amend(T)	8-1-2013
813-090-0100	6-21-2013	Adopt(T)	8-1-2013
813-110-0005	6-21-2013	Amend(T)	8-1-2013
813-110-0010	6-21-2013	Amend(T)	8-1-2013
813-110-0012	6-21-2013	Suspend	8-1-2013
813-110-0013	6-21-2013	Suspend	8-1-2013
813-110-0015	6-21-2013	Amend(T)	8-1-2013
813-110-0020	6-21-2013	Amend(T)	8-1-2013
813-110-0021	6-21-2013	Amend(T)	8-1-2013
813-110-0022	6-21-2013	Amend(T)	8-1-2013
813-110-0023	6-21-2013	Suspend	8-1-2013
813-110-0024	6-21-2013	Adopt(T)	8-1-2013
813-110-0025	6-21-2013	Amend(T)	8-1-2013
813-110-0027	6-21-2013	Adopt(T)	8-1-2013
813-110-0030	6-21-2013	Amend(T)	8-1-2013
813-110-0032	6-21-2013	Adopt(T)	8-1-2013
813-110-0033	6-21-2013	Suspend	8-1-2013
813-110-0034	6-21-2013	Adopt(T)	8-1-2013
813-110-0035	6-21-2013	Amend(T)	8-1-2013
813-110-0037	6-21-2013	Adopt(T)	8-1-2013
813-110-0040	6-21-2013	Amend(T)	8-1-2013
813-110-0045	6-21-2013	Adopt(T)	8-1-2013

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813-120-0010	6-21-2013	Amend(T)	8-1-2013
813-120-0015	6-21-2013	Adopt(T)	8-1-2013
813-120-0020	6-21-2013	Suspend	8-1-2013
813-120-0025	6-21-2013	Amend(T)	8-1-2013
813-120-0032	6-21-2013	Amend(T)	8-1-2013
813-120-0035	6-21-2013	Amend(T)	8-1-2013
813-120-0040	6-21-2013	Suspend	8-1-2013
813-120-0045	6-21-2013	Amend(T)	8-1-2013
813-120-0047	6-21-2013	Amend(T)	8-1-2013
813-120-0050	6-21-2013	Amend(T)	8-1-2013
813-120-0060	6-21-2013	Suspend	8-1-2013
813-120-0070	6-21-2013	Renumber	8-1-2013
813-120-0080	6-21-2013	Renumber	8-1-2013
813-120-0090	6-21-2013	Renumber	8-1-2013
813-120-0105	6-21-2013	Renumber	8-1-2013
813-120-0110	6-21-2013	Amend(T)	8-1-2013
813-120-0120	6-21-2013	Amend(T)	8-1-2013
813-120-0130	6-21-2013	Amend(T)	8-1-2013
813-120-0140	6-21-2013	Suspend	8-1-2013
813-120-0142	6-21-2013	Adopt(T)	8-1-2013
813-130-0000	6-21-2013	Amend(T)	8-1-2013
813-130-0010	6-21-2013	Amend(T)	8-1-2013
813-130-0020	6-21-2013	Amend(T)	8-1-2013
813-130-0030	6-21-2013	Amend(T)	8-1-2013
813-130-0040	6-21-2013	Amend(T)	8-1-2013
813-130-0050	6-21-2013	Amend(T)	8-1-2013
813-130-0060	6-21-2013	Amend(T)	8-1-2013
813-130-0070	6-21-2013	Amend(T)	8-1-2013
813-130-0080	6-21-2013	Amend(T)	8-1-2013
813-130-0090	6-21-2013	Amend(T)	8-1-2013
813-130-0100	6-21-2013	Amend(T)	8-1-2013
813-130-0110	6-21-2013	Amend(T)	8-1-2013
813-130-0120	6-21-2013	Amend(T)	8-1-2013
813-130-0130	6-21-2013	Suspend	8-1-2013
813-130-0140	6-21-2013	Suspend	8-1-2013
813-130-0150	6-21-2013	Amend(T)	8-1-2013
813-205-0000	6-21-2013	Amend(T)	8-1-2013
813-205-0010	6-21-2013	Suspend	8-1-2013
813-205-0020	6-21-2013	Amend(T)	8-1-2013
813-205-0030	6-21-2013	Amend(T)	8-1-2013
813-205-0040	6-21-2013	Amend(T)	8-1-2013
813-205-0050	6-21-2013	Amend(T)	8-1-2013
813-205-0051	6-21-2013	Amend(T)	8-1-2013
813-205-0052	6-21-2013	Amend(T)	8-1-2013
813-205-0060	6-21-2013	Amend(T)	8-1-2013
813-205-0070	6-21-2013	Amend(T)	8-1-2013
813-205-0080	6-21-2013	Amend(T)	8-1-2013
813-205-0082	6-21-2013	Adopt(T)	8-1-2013
813-205-0085	6-21-2013	Amend(T)	8-1-2013
813-205-0100	6-21-2013	Amend(T)	8-1-2013
813-205-0110	6-21-2013	Amend(T)	8-1-2013
813-205-0120	6-21-2013	Amend(T)	8-1-2013
813-205-0130	6-21-2013	Amend(T)	8-1-2013
813-205-0140	6-21-2013	Suspend	8-1-2013
813-205-0145	6-21-2013	Adopt(T)	8-1-2013
813-205-0150	6-21-2013	Adopt(T)	8-1-2013
813-250-0000	12-6-2012	Amend(T)	1-1-2013
813-250-0000	6-4-2013	Amend	7-1-2013
813-250-0000(T)	6-4-2013	Repeal	7-1-2013
813-250-0010	12-6-2012	Suspend	1-1-2013
813-250-0010	6-4-2013	Repeal	7-1-2013
813-250-0020	12-6-2012	Amend(T)	1-1-2013
813-250-0020	6-4-2013	Amend	7-1-2013
813-250-0020(T)	6-4-2013	Repeal	7-1-2013
813-250-0030	12-6-2012	Amend(T)	1-1-2013
813-250-0030	6-4-2013	Amend	7-1-2013
813-250-0030(T)	6-4-2013	Repeal	7-1-2013
813-250-0040	12-6-2012	Amend(T)	1-1-2013
813-250-0040	6-4-2013	Amend	7-1-2013
813-250-0040(T)	6-4-2013	Repeal	7-1-2013
813-250-0050	12-6-2012	Suspend	1-1-2013
813-250-0050	6-4-2013	Repeal	7-1-2013
818-001-0002	7-1-2013	Amend	6-1-2013
818-001-0087	7-1-2013	Amend	6-1-2013
818-012-0005	7-1-2013	Amend	6-1-2013
818-026-0000	7-1-2013	Amend	6-1-2013
818-026-0020	7-1-2013	Amend	6-1-2013
818-026-0060	7-1-2013	Amend	6-1-2013
818-026-0065	7-1-2013	Amend	6-1-2013
818-026-0070	7-1-2013	Amend	6-1-2013
818-026-0140	7-1-2013	Adopt(T)	8-1-2013
818-035-0020	7-1-2013	Amend	6-1-2013
818-035-0066	7-1-2013	Amend	6-1-2013
818-035-0072	7-1-2013	Amend	6-1-2013
818-042-0090	7-1-2013	Amend	6-1-2013
818-042-0095	7-1-2013	Amend	6-1-2013
818-042-0110	7-1-2013	Amend	6-1-2013
820-001-0025	3-13-2013	Adopt	4-1-2013
820-010-0200	3-13-2013	Amend	4-1-2013
820-010-0204	3-13-2013	Amend	4-1-2013
820-010-0205	3-13-2013	Amend	4-1-2013
820-010-0206	3-13-2013	Amend	4-1-2013
820-010-0207	3-13-2013	Amend	4-1-2013
820-010-0208	3-13-2013	Amend	4-1-2013
820-010-0212	3-13-2013	Amend	4-1-2013
820-010-0213	3-13-2013	Amend	4-1-2013
820-010-0214	3-13-2013	Amend	4-1-2013
820-010-0215	3-13-2013	Amend	4-1-2013
820-010-0225	3-13-2013	Amend	4-1-2013
820-010-0225	7-10-2013	Amend(T)	8-1-2013
820-010-0226	3-13-2013	Amend	4-1-2013
820-010-0226	7-10-2013	Amend(T)	8-1-2013
820-010-0325	6-17-2013	Amend	8-1-2013
820-010-0415	3-13-2013	Amend	4-1-2013
820-010-0425	3-13-2013	Amend	4-1-2013
820-010-0427	3-13-2013	Amend	4-1-2013
820-010-0480	3-13-2013	Amend	4-1-2013
820-010-0520	3-13-2013	Amend	4-1-2013
820-010-0635	3-13-2013	Amend	4-1-2013
820-010-0720	3-13-2013	Amend	4-1-2013

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820-050-0001	6-17-2013	Adopt	8-1-2013
820-050-0001(T)	6-17-2013	Repeal	8-1-2013
820-050-0010	3-13-2013	Adopt	4-1-2013
830-001-0000	3-29-2013	Amend	5-1-2013
830-020-0030	3-29-2013	Amend	5-1-2013
830-020-0040	3-29-2013	Amend	5-1-2013
830-030-0000	3-29-2013	Amend	5-1-2013
830-030-0070	3-29-2013	Amend	5-1-2013
830-030-0100	3-29-2013	Amend	5-1-2013
830-040-0005	3-29-2013	Amend	5-1-2013
830-040-0050	3-29-2013	Amend	5-1-2013
833-020-0051	2-1-2013	Amend	2-1-2013
833-020-0081	2-1-2013	Amend	2-1-2013
833-030-0041	2-1-2013	Amend	2-1-2013
833-040-0041	2-1-2013	Amend	2-1-2013
836-011-0000	2-6-2013	Amend	3-1-2013
836-031-0765	2-6-2013	Amend	3-1-2013
836-053-0064	6-17-2013	Adopt(T)	8-1-2013
836-053-0065	6-17-2013	Amend(T)	8-1-2013
836-053-0471	6-17-2013	Amend(T)	8-1-2013
836-053-1404	12-20-2012	Amend(T)	2-1-2013
836-053-1404	6-17-2013	Amend	7-1-2013
836-053-1405	12-20-2012	Amend(T)	2-1-2013
836-053-1405	6-17-2013	Amend	7-1-2013
837-085-0030	6-26-2013	Amend	8-1-2013
837-085-0040	2-1-2013	Amend	3-1-2013
837-085-0040	6-26-2013	Amend	8-1-2013
837-085-0070	2-1-2013	Amend	3-1-2013
837-085-0080	2-1-2013	Amend	3-1-2013
837-085-0080	6-26-2013	Amend	8-1-2013
837-085-0300	6-26-2013	Amend	8-1-2013
837-090-1030	7-1-2013	Amend	8-1-2013
837-090-1145	6-30-2013	Amend	8-1-2013
837-120-0080	7-1-2013	Amend	8-1-2013
839-009-0335	11-21-2012	Amend	1-1-2013
839-009-0390	11-21-2012	Amend	1-1-2013
839-009-0410	11-21-2012	Amend	1-1-2013
839-025-0700	1-1-2013	Amend	2-1-2013
839-025-0700	3-25-2013	Amend	5-1-2013
845-006-0335	7-15-2013	Amend(T)	8-1-2013
845-006-0345	4-1-2013	Amend	4-1-2013
845-006-0347	4-1-2013	Amend	4-1-2013
845-006-0392	7-15-2013	Amend(T)	8-1-2013
845-006-0396	7-15-2013	Amend(T)	8-1-2013
845-009-0010	5-10-2013	Amend(T)	6-1-2013
845-009-0015	5-10-2013	Amend(T)	6-1-2013
845-015-0170	1-1-2013	Amend	2-1-2013
847-001-0035	7-12-2013	Adopt	8-1-2013
847-001-0040	7-15-2013	Adopt(T)	8-1-2013
847-005-0005	4-5-2013	Amend	5-1-2013
847-005-0005	7-15-2013	Amend(T)	8-1-2013
847-005-0005(T)	4-5-2013	Repeal	5-1-2013
847-008-0003	7-15-2013	Adopt(T)	8-1-2013
847-008-0040	1-11-2013	Amend(T)	2-1-2013
847-008-0040	4-5-2013	Amend	5-1-2013
847-008-0040(T)	4-5-2013	Repeal	5-1-2013
847-008-0065	1-11-2013	Amend	2-1-2013
847-008-0068	7-15-2013	Amend(T)	8-1-2013
847-010-0063	7-15-2013	Amend(T)	8-1-2013
847-012-0000	4-5-2013	Amend	5-1-2013
847-020-0100	4-5-2013	Amend	5-1-2013
847-020-0110	4-5-2013	Amend	5-1-2013
847-020-0115	4-5-2013	Am. & Ren.	5-1-2013
847-020-0120	4-5-2013	Amend	5-1-2013
847-020-0130	4-5-2013	Amend	5-1-2013
847-020-0140	4-5-2013	Amend	5-1-2013
847-020-0150	4-5-2013	Amend	5-1-2013
847-020-0160	4-5-2013	Amend	5-1-2013
847-020-0170	4-5-2013	Amend	5-1-2013
847-020-0180	4-5-2013	Repeal	5-1-2013
847-020-0182	4-5-2013	Amend	5-1-2013
847-020-0183	4-5-2013	Amend	5-1-2013
847-020-0190	4-5-2013	Amend	5-1-2013
847-035-0011	4-5-2013	Amend	5-1-2013
847-035-0030	4-5-2013	Amend	5-1-2013
847-050-0027	1-11-2013	Amend	2-1-2013
847-050-0027	7-15-2013	Amend(T)	8-1-2013
847-050-0041	1-11-2013	Amend	2-1-2013
847-050-0041(T)	1-11-2013	Repeal	2-1-2013
847-050-0042	7-15-2013	Amend(T)	8-1-2013
847-050-0065	1-11-2013	Amend	2-1-2013
847-050-0065(T)	1-11-2013	Repeal	2-1-2013
847-070-0050	7-12-2013	Amend	8-1-2013
847-080-0002	7-12-2013	Amend	8-1-2013
847-080-0010	7-12-2013	Amend	8-1-2013
847-080-0013	7-12-2013	Amend	8-1-2013
847-080-0017	7-12-2013	Amend	8-1-2013
847-080-0018	7-12-2013	Amend	8-1-2013
847-080-0021	7-12-2013	Adopt	8-1-2013
847-080-0022	7-12-2013	Amend	8-1-2013
847-080-0028	7-12-2013	Adopt	8-1-2013
847-080-0030	7-12-2013	Amend	8-1-2013
848-005-0010	7-1-2013	Amend	7-1-2013
848-005-0020	1-1-2013	Amend(T)	1-1-2013
850-001-0015	4-12-2013	Amend	5-1-2013
850-030-0035	4-12-2013	Amend	5-1-2013
850-035-0230	4-12-2013	Amend	5-1-2013
851-050-0000	4-1-2013	Amend	4-1-2013
851-050-0000(T)	4-1-2013	Repeal	4-1-2013
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851-050-0006	6-1-2013	Amend	6-1-2013
851-050-0008	6-1-2013	Amend	6-1-2013
851-050-0009	4-1-2013	Amend	4-1-2013
851-050-0009(T)	4-1-2013	Repeal	4-1-2013
851-050-0138	6-1-2013	Amend	6-1-2013
851-052-0020	6-1-2013	Amend	6-1-2013
851-052-0030	6-1-2013	Amend	6-1-2013
851-052-0040	4-1-2013	Amend	4-1-2013
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851-054-0060(T)	4-1-2013	Repeal	4-1-2013
851-054-0100	4-1-2013	Amend	4-1-2013
851-054-0100(T)	4-1-2013	Repeal	4-1-2013
851-062-0100	4-1-2013	Amend	4-1-2013
851-070-0005	4-1-2013	Amend	4-1-2013
851-070-0030	4-1-2013	Amend	4-1-2013
851-070-0040	4-1-2013	Amend	4-1-2013
851-070-0050	4-1-2013	Amend	4-1-2013
851-070-0100	4-1-2013	Amend	4-1-2013
852-001-0001	1-3-2013	Amend	2-1-2013
852-001-0002	1-3-2013	Amend	2-1-2013
852-005-0005	1-3-2013	Amend	2-1-2013
852-005-0015	1-3-2013	Amend	2-1-2013
852-005-0030	1-3-2013	Amend	2-1-2013
852-005-0040	1-3-2013	Repeal	2-1-2013
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852-010-0015	1-3-2013	Amend	2-1-2013
852-010-0020	1-3-2013	Amend	2-1-2013
852-010-0022	1-3-2013	Amend	2-1-2013
852-010-0023	1-3-2013	Amend	2-1-2013
852-010-0030	1-3-2013	Amend	2-1-2013
852-010-0035	1-3-2013	Amend	2-1-2013
852-010-0051	1-3-2013	Amend	2-1-2013
852-010-0080	1-3-2013	Amend	2-1-2013
852-020-0029	1-3-2013	Amend	2-1-2013
852-020-0031	1-3-2013	Amend	2-1-2013
852-020-0035	1-3-2013	Amend	2-1-2013
852-020-0045	1-3-2013	Amend	2-1-2013
852-020-0050	1-3-2013	Amend	2-1-2013
852-020-0060	1-3-2013	Amend	2-1-2013
852-020-0070	1-3-2013	Amend	2-1-2013
852-050-0001	1-3-2013	Amend	2-1-2013
852-050-0005	1-3-2013	Amend	2-1-2013
852-050-0006	1-3-2013	Amend	2-1-2013
852-050-0012	1-3-2013	Amend	2-1-2013
852-050-0013	1-3-2013	Amend	2-1-2013
852-050-0014	1-3-2013	Amend	2-1-2013
852-050-0016	1-3-2013	Amend	2-1-2013
852-050-0018	1-3-2013	Amend	2-1-2013
852-050-0021	1-3-2013	Amend	2-1-2013
852-050-0022	1-3-2013	Adopt	2-1-2013
852-050-0025	1-3-2013	Amend	2-1-2013
852-060-0025	1-3-2013	Amend	2-1-2013
852-060-0027	1-3-2013	Amend	2-1-2013
852-060-0060	1-3-2013	Amend	2-1-2013
852-060-0065	1-3-2013	Amend	2-1-2013
852-060-0070	1-3-2013	Amend	2-1-2013
852-070-0005	1-3-2013	Amend	2-1-2013
852-070-0010	1-3-2013	Amend	2-1-2013
852-070-0016	1-3-2013	Amend	2-1-2013
852-070-0020	1-3-2013	Amend	2-1-2013
852-070-0025	1-3-2013	Amend	2-1-2013
852-070-0030	1-3-2013	Amend	2-1-2013
852-070-0035	1-3-2013	Amend	2-1-2013
852-070-0040	1-3-2013	Repeal	2-1-2013
852-070-0045	1-3-2013	Amend	2-1-2013
852-070-0050	1-3-2013	Repeal	2-1-2013
852-070-0055	1-3-2013	Amend	2-1-2013
852-070-0060	1-3-2013	Am. & Ren.	2-1-2013
852-080-0020	1-3-2013	Amend	2-1-2013
852-080-0025	1-3-2013	Amend	2-1-2013
852-080-0030	1-3-2013	Amend	2-1-2013
852-080-0040	1-3-2013	Amend	2-1-2013
855-041-0005	12-17-2012	Am. & Ren.	2-1-2013
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855-041-0015	12-17-2012	Am. & Ren.	2-1-2013
855-041-0016	12-17-2012	Renumber	2-1-2013
855-041-0017	12-17-2012	Renumber	2-1-2013
855-041-0020	12-17-2012	Renumber	2-1-2013
855-041-0025	12-17-2012	Renumber	2-1-2013
855-041-0026	12-17-2012	Am. & Ren.	2-1-2013
855-041-0030	12-17-2012	Repeal	2-1-2013
855-041-0035	12-17-2012	Am. & Ren.	2-1-2013
855-041-0036	12-17-2012	Renumber	2-1-2013
855-041-0037	12-17-2012	Renumber	2-1-2013
855-041-0040	12-17-2012	Renumber	2-1-2013
855-041-0055	12-17-2012	Renumber	2-1-2013
855-041-0056	12-17-2012	Renumber	2-1-2013
855-041-0057	12-17-2012	Renumber	2-1-2013
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855-041-0060	12-17-2012	Am. & Ren.	2-1-2013
855-041-0060	12-17-2012	Am. & Ren.	2-1-2013
855-041-0061	12-17-2012	Renumber	2-1-2013
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855-041-0065	12-17-2012	Am. & Ren.	2-1-2013
855-041-0065	12-17-2012	Am. & Ren.	2-1-2013
855-041-0065	12-17-2012	Am. & Ren.	2-1-2013
855-041-0075	12-17-2012	Renumber	2-1-2013
855-041-0080	12-17-2012	Renumber	2-1-2013
855-041-0086	12-17-2012	Renumber	2-1-2013
855-041-0095	12-17-2012	Renumber	2-1-2013
855-041-0103	12-17-2012	Renumber	2-1-2013
855-041-0135	12-17-2012	Am. & Ren.	2-1-2013
855-041-0140	12-17-2012	Renumber	2-1-2013
855-041-0145	12-17-2012	Am. & Ren.	2-1-2013
855-041-0160	12-17-2012	Am. & Ren.	2-1-2013
855-041-0162	12-17-2012	Am. & Ren.	2-1-2013
855-041-0164	12-17-2012	Renumber	2-1-2013
855-041-0165	12-17-2012	Am. & Ren.	2-1-2013
855-041-0170	12-17-2012	Renumber	2-1-2013
855-041-0173	12-17-2012	Renumber	2-1-2013
855-041-0175	12-17-2012	Renumber	2-1-2013
855-041-0177	12-17-2012	Renumber	2-1-2013
855-041-0300	12-17-2012	Renumber	2-1-2013
855-041-0350	12-17-2012	Renumber	2-1-2013
855-041-0355	12-17-2012	Renumber	2-1-2013
855-041-0360	12-17-2012	Am. & Ren.	2-1-2013

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855-041-0600	12-17-2012	Renumber	2-1-2013
855-041-0610	12-17-2012	Renumber	2-1-2013
855-041-0620	12-17-2012	Am. & Ren.	2-1-2013
855-041-0645	12-17-2012	Renumber	2-1-2013
855-041-6410	12-21-2012	Amend	2-1-2013
855-060-0004	3-7-2013	Amend(T)	4-1-2013
855-065-0005	12-13-2012	Amend	1-1-2013
855-110-0005	4-5-2013	Amend(T)	5-1-2013
855-110-0005	7-1-2013	Amend(T)	8-1-2013
855-110-0005	7-9-2013	Amend(T)	8-1-2013
855-110-0007	12-13-2012	Amend	1-1-2013
855-110-0007	7-1-2013	Amend(T)	8-1-2013
855-110-0007	7-9-2013	Amend(T)	8-1-2013
855-110-0010	7-1-2013	Amend(T)	8-1-2013
855-110-0010	7-9-2013	Amend(T)	8-1-2013
856-010-0016	7-1-2013	Amend	8-1-2013
856-030-0045	1-31-2013	Adopt	3-1-2013
858-010-0010	2-5-2013	Amend	3-1-2013
858-010-0010	7-15-2013	Amend	8-1-2013
858-010-0010(T)	2-5-2013	Repeal	3-1-2013
858-010-0015	2-5-2013	Amend	3-1-2013
858-010-0015(T)	2-5-2013	Repeal	3-1-2013
858-010-0016	11-20-2012	Amend(T)	1-1-2013
858-010-0016	2-5-2013	Amend	3-1-2013
858-010-0016(T)	2-5-2013	Repeal	3-1-2013
858-010-0017	11-20-2012	Amend(T)	1-1-2013
858-010-0017	2-5-2013	Amend	3-1-2013
858-010-0017(T)	11-20-2012	Suspend	1-1-2013
858-010-0017(T)	2-5-2013	Repeal	3-1-2013
858-010-0030	2-5-2013	Amend	3-1-2013
858-010-0030(T)	2-5-2013	Repeal	3-1-2013
858-010-0050	11-19-2012	Amend	1-1-2013
858-020-0025	2-5-2013	Amend	3-1-2013
858-020-0025(T)	2-5-2013	Repeal	3-1-2013
859-070-0010	3-1-2013	Amend(T)	4-1-2013
859-070-0010	6-20-2013	Amend	8-1-2013
859-070-0010(T)	6-20-2013	Repeal	8-1-2013
859-070-0015	3-1-2013	Amend(T)	4-1-2013
859-070-0015	6-20-2013	Amend	8-1-2013
859-070-0015(T)	6-20-2013	Repeal	8-1-2013
860-021-0170	2-14-2013	Adopt	3-1-2013
860-024-0020	5-30-2013	Amend	7-1-2013
860-024-0021	5-30-2013	Amend	7-1-2013
860-027-0015	3-21-2013	Amend	5-1-2013
860-027-0050	5-17-2013	Amend	7-1-2013
860-032-0007	12-17-2012	Amend	2-1-2013
860-033-0001	6-28-2013	Amend(T)	8-1-2013
860-033-0005	6-28-2013	Amend(T)	8-1-2013
860-033-0006	6-28-2013	Amend(T)	8-1-2013
860-033-0007	6-28-2013	Amend(T)	8-1-2013
860-033-0010	6-28-2013	Amend(T)	8-1-2013
860-033-0030	6-28-2013	Amend(T)	8-1-2013
860-033-0035	6-28-2013	Amend(T)	8-1-2013
860-033-0040	6-28-2013	Amend(T)	8-1-2013
860-033-0045	6-28-2013	Amend(T)	8-1-2013
860-033-0046	6-28-2013	Amend(T)	8-1-2013
860-033-0050	6-28-2013	Amend(T)	8-1-2013
860-033-0055(T)	6-28-2013	Suspend	8-1-2013
860-033-0100	6-28-2013	Amend(T)	8-1-2013
860-033-0110	6-28-2013	Adopt(T)	8-1-2013
860-033-0530	6-28-2013	Amend(T)	8-1-2013
860-033-0535	6-28-2013	Amend(T)	8-1-2013
860-033-0536	6-28-2013	Amend(T)	8-1-2013
860-033-0537	6-28-2013	Amend(T)	8-1-2013
860-033-0540	6-28-2013	Amend(T)	8-1-2013
860-034-0393	5-17-2013	Amend	7-1-2013
860-034-0730	5-17-2013	Amend	7-1-2013
863-015-0215	5-13-2013	Amend(T)	6-1-2013
863-020-0000	2-1-2013	Amend	2-1-2013
863-020-0005	2-1-2013	Amend	2-1-2013
863-020-0007	2-1-2013	Amend	2-1-2013
863-020-0008	2-1-2013	Repeal	2-1-2013
863-020-0010	2-1-2013	Amend	2-1-2013
863-020-0015	2-1-2013	Amend	2-1-2013
863-020-0020	2-1-2013	Amend	2-1-2013
863-020-0025	2-1-2013	Amend	2-1-2013
863-020-0030	2-1-2013	Amend	2-1-2013
863-020-0035	2-1-2013	Amend	2-1-2013
863-020-0040	2-1-2013	Amend	2-1-2013
863-020-0045	2-1-2013	Amend	2-1-2013
863-020-0050	2-1-2013	Amend	2-1-2013
863-020-0055	2-1-2013	Amend	2-1-2013
863-020-0060	2-1-2013	Amend	2-1-2013
863-020-0065	2-1-2013	Amend	2-1-2013
863-022-0000	2-1-2013	Amend	2-1-2013
863-022-0005	2-1-2013	Amend	2-1-2013
863-022-0010	2-1-2013	Amend	2-1-2013
863-022-0015	2-1-2013	Amend	2-1-2013
863-022-0020	2-1-2013	Amend	2-1-2013
863-022-0022	2-1-2013	Adopt	2-1-2013
863-022-0025	2-1-2013	Amend	2-1-2013
863-022-0030	2-1-2013	Amend	2-1-2013
863-022-0035	2-1-2013	Amend	2-1-2013
863-022-0040	2-1-2013	Repeal	2-1-2013
863-022-0045	2-1-2013	Amend	2-1-2013
863-022-0050	2-1-2013	Amend	2-1-2013
863-022-0052	2-1-2013	Adopt	2-1-2013
863-022-0055	2-1-2013	Amend	2-1-2013
863-022-0060	2-1-2013	Amend	2-1-2013
877-001-0006	1-1-2013	Amend	1-1-2013
877-001-0009	1-1-2013	Adopt	1-1-2013
877-001-0020	1-1-2013	Amend	1-1-2013
877-001-0025	1-1-2013	Amend	1-1-2013
877-001-0028	1-1-2013	Adopt	1-1-2013
877-020-0008	1-1-2013	Amend	1-1-2013
877-020-0010	1-1-2013	Amend	1-1-2013
877-020-0055	1-1-2013	Amend	1-1-2013
877-020-0057	1-1-2013	Amend	1-1-2013
877-025-0006	1-1-2013	Amend	1-1-2013
877-025-0011	1-1-2013	Amend	1-1-2013
877-025-0016	1-1-2013	Repeal	1-1-2013

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877-030-0040	1-1-2013	Amend	1-1-2013
877-040-0055	1-1-2013	Repeal	1-1-2013
918-001-0010	4-1-2013	Amend	4-1-2013
918-030-0100	12-22-2012	Amend(T)	2-1-2013
918-030-0100	4-1-2013	Amend	5-1-2013
918-030-0120	12-22-2012	Amend(T)	2-1-2013
918-030-0120	4-1-2013	Amend	5-1-2013
918-030-0125	12-22-2012	Amend(T)	2-1-2013
918-030-0125	4-1-2013	Amend	5-1-2013
918-030-0130	12-22-2012	Amend(T)	2-1-2013
918-030-0130	4-1-2013	Amend	5-1-2013
918-030-0135	12-22-2012	Amend(T)	2-1-2013
918-030-0135	4-1-2013	Amend	5-1-2013
918-098-1000	2-2-2013	Amend(T)	3-1-2013
918-098-1530	1-1-2013	Amend	2-1-2013
918-098-1530(T)	1-1-2013	Repeal	2-1-2013
918-098-1550	1-1-2013	Amend	2-1-2013
918-098-1550(T)	1-1-2013	Repeal	2-1-2013
918-100-0125	3-1-2013	Adopt(T)	4-1-2013
918-305-0100	5-1-2013	Amend	5-1-2013
918-305-0105	1-1-2013	Amend(T)	1-1-2013
918-305-0105	5-1-2013	Amend	5-1-2013
918-305-0105(T)	1-1-2013	Suspend	1-1-2013
918-305-0105(T)	5-1-2013	Repeal	5-1-2013
918-674-0057	1-1-2013	Adopt	2-1-2013
918-695-0031	4-15-2013	Adopt(T)	5-1-2013
918-750-0115	1-1-2013	Adopt	2-1-2013
945-020-0010	12-13-2012	Adopt	1-1-2013
945-020-0020	12-13-2012	Adopt	1-1-2013
945-020-0040	7-9-2013	Adopt	8-1-2013
945-030-0010	3-18-2013	Adopt	5-1-2013
945-030-0010	5-28-2013	Suspend	7-1-2013
945-030-0020	3-18-2013	Adopt	5-1-2013
945-030-0030	3-18-2013	Adopt	5-1-2013
945-030-0030	5-28-2013	Amend(T)	7-1-2013
945-030-0040	3-18-2013	Adopt	5-1-2013
945-030-0040	5-28-2013	Amend(T)	7-1-2013
945-050-0010	4-15-2013	Adopt	5-1-2013
945-050-0020	4-15-2013	Adopt	5-1-2013
966-100-0100	1-2-2013	Adopt	2-1-2013
966-100-0200	1-2-2013	Adopt	2-1-2013
966-100-0300	1-2-2013	Adopt	2-1-2013
966-100-0400	1-2-2013	Adopt	2-1-2013
966-100-0500	1-2-2013	Adopt	2-1-2013